State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.2 Face Sheet

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1.4 State Overview

Geography

The geographic and demographic factors that account for Maine's uniqueness among the New England states are the very same factors that create complex challenges for the Bureau of Health, Division of Community & Family Health, as it strives to improve health outcomes for the state's 1.2 million residents.

All other five New England states can fit into the land area occupied by the state of Maine. However, this large area accounts for the 14th lowest population density in the nation and an average of only ~40 people per square mile, as compared to Massachusetts with a population density of ~777 people per square mile. Even this average population figure is deceptive in Maine, because the majority of our citizens live along the coast and in the southern third of the state.

Maine has sixteen counties of significantly varying sizes and population densities. Health care providers and infrastructure are distributed in direct relationship to population density. The largest, and most sparsely populated county, is Aroostook to the extreme north with 6,672 square miles, a population of 77,094 (~11 people per square mile), and only 33 primary care providers (i.e. pediatricians, general practitioners and family practitioners). These providers must serve a very large geographic area with essentially no major thoroughfares, making efficient and cost-effective access to health care a challenge. In contrast, Cumberland County, one of the smaller and more densely populated counties to the south, has 835 square miles, a population of 251,438 (300 people per square mile), 158 providers (pediatricians, general practitioners and family practitioners), and an extensive network of surface streets and roads.

Maine has three major cities: Portland population 62,000; Bangor population 31,000; and Lewiston population 35,000. Collectively these cities account for only 10% of the state's residents. While 80% of American citizens reside in metropolitan areas, the majority of Maine's citizens continue to reside in small rural towns and cities that comprise the core of Maine's governmental structure. Almost 500 of these municipalities maintain the town meeting format of direct democracy.

Demographics

In 1998 the maternal and child population in Maine accounted for approximately 48% of the total population of 1,243,316 predominantly Caucasian (98% White) citizens. Women ages 15 through 44 years represented almost 22% (276,187) of our citizens and children ages 0-19 years of age comprised 26% (326,260) of the population. Of those children, 5% (67,147) were 5 years and younger.

In 1970 family couples made up 72% of all households in Maine. By 1990 only 60% of our households were headed by couples. The female headed households account for almost 34% of households living below the poverty level. It is also important to note that 55% of Maine's women and their children live in rural areas. Maine gained 5,486 new residents during the time span between 1998-1999. We do not anticipate any significant changes to our population count or distribution.

There were 13,685 live births in 1998, representing one of the lowest birth rates in the nation. Maine's 1998 infant mortality rate was low at 6.2/1000, as compared to a national infant mortality rate of 7.2/1000. The adolescent pregnancy rate in 1998 for adolescents ages 10-14 years is 0.3/1000 and 30.4/1000 for those ages 15-19 years. A more accurate reflection is the five-year average (1994-1998): 0.3/1000 for 10-14 year olds and 32.5/1000 for 15-19 year olds. (1998 data is preliminary)

Ethnically Maine is predominantly white (98%), with small minority populations including four tribes of Native Americans; African Americans; Southeast Asians, and Hispanics. Maine welcomed approximately 220 newly arriving refugees (Catholic Charities) during FY99 (10/01/98-9/30/99). These individuals were from Bosnia, Iran, Iraq, the former Soviet Union, Liberia, Somalia, Sudan, Afghanistan and Cuba. Newly arriving refugees settle primarily in the southern portion of the state (Portland, Lewiston, Biddeford, and Sanford) where there are greater social service resources and employment opportunities. All of these ethnically diverse citizens represent approximately 2% of the state's total population.

Current Socioeconomic Indicators

Maine's three largest sources of private sector revenue are the lumber industry, fishing industry and tourism. 20% of Maine's workforce is employed in manufacturing, 22% in retail/wholesale trade; 9.2% in health services; 5.6% in finance/insurance/real estate; 4.4% in public administration; 2% in farming and the remaining workers are employed in a variety of small businesses and cottage industries. Underemployment is a chronic problem due to the seasonal nature of our economy. The unemployment rate uncorrected for seasonal variation as reported by the Bureau of Labor Statistics for January 1999 is 4.1%. The unemployment rate declines to 3.6% when seasonally adjusted.

Maine's rate of poverty ranks 20th among the 50 states, hovering close to the national average. However, this ranking is very deceptive because the U.S. Bureau of Labor's most recent wage statistics (1998) show that in terms of annual wages Maine ranks 40th in the U.S. and last in New England. Maine's average wage ($25,875) would have to increase 39% to equal the New England average wage ($35,962). Our average wage is also significantly lower than the national average wage of $31,908. These factors keep many Maine residents, our "working poor", on the brink of poverty even though the state's actual poverty rate remains close to the national average.

The median annual earnings for women in Maine working full-time is $16,540. One third of our women live at less than 200% of the poverty level. One in four Maine children live in poverty. In 1997 an estimated 40% live in homes where the income is less than 200% of the poverty level. There were 13.5% of children aged 0-17 years receiving food stamp benefits, 18,676 children received free/reduced price breakfast and 31.7% received some type of subsidized lunch.

Twice a year, in July and March, the Maine State Housing Authority conducts detailed surveys of clients using homeless shelters. In March 1999 there was an unduplicated count of 1,188 clients using shelter beds. 32% were women and 25.1% were children under 18 years of age. In July 1999 1,401 clients used shelters; of these 34% were women and 21.3% were children under 18 years of age. Considering the

dramatic difference in Maine's weather conditions when one compares March to July, there is a surprising consistency in shelter usage among homeless women and children.

Health Disparities

The majority of states have traditionally reported health disparities as health status differences between Blacks (African Americans) and Whites (Caucasians). In Maine our statistics don't show this ethnic disparity, probably because there is some statistical insensitivity to the small numbers of Blacks citizens in Maine. Despite this, there do seem to be some differences if we compare white and non-white (Black and all other ethnic origins). We plan to look at this more closely. Maine's disparities are not associated with racial/ethnic variables, but are correlated with differences in education, income and the low population densities of our rural areas. For example, PRAMS data shows a marked disparity in the smoking status of women with those from poor and rural areas reporting an increased incidence of smoking during pregnancy.

Disparities in infant mortality are correlated with socio-economic conditions and community capacity for public health. For the most part, the prevalence of cardiovascular disease increases in areas with lower socio-economic status, although there are some exceptions like Franklin County. Although this county is among the poorest in the state, its incidence of cardiovascular disease is similar to our most affluent county. As the State health agency we need to analyze this finding and characterize why we have some outliers like Franklin County.

The WIC data reveals a lower number of breastfeeding mothers in their program as compared to mothers not participating in WIC. We postulate this disparity is related to education and experience. Attention is being paid to these factors in WIC's current strategic plan.

Lead poisoning in Maine is not necessarily related to a lower socio-economic status. We have found that upper and middle-class families who are renovating older homes also risk exposing their children to lead poisoning.

In his 1999 paper "The Health Status of Maine's Native American Population" Paul Kuehnert, Director of the Bureau of Health's Division of Disease Control, identified several areas of concern for this minority population. Specifically, they were noted to have lower per capita income, higher unemployment rates and lower high school completion rates as compared to Maine as a whole. In addition, their population was found to be younger and experienced an increased birth rate. Native American teen pregnancy rates were found to be significantly higher when compared to all of Maine. At the time of this paper the increased birth rate was not accompanied by an increase in low birth weights or infant mortality, although Infant Mortality Review has observed wide fluctuation is these numbers over the past ten years. Additional findings worthy of further exploration are a lower crude mortality yet significantly shorter life expectancy. No clear explanation for this discrepancy was identified. Indeed, Native Americans were found to have experienced a decrease in mortality related to cardiovascular disease yet an increase in cancer mortality, especially related to lung cancer. This may be a result of increased tobacco use but this needs to be

explored more fully. It is important for MCH to recognize and respond to specific needs within this Native American population even though they have their own system of health centers and HIS support.

Overview of Political Influences in the Past Five Years that Impacted the MCH Programs

In 1996 Maine's Bureau of Health was restructured in response to a mandate from the legislature to reduce the number of divisions within all State Bureaus. Four divisions, including the Division of Maternal and Child Health, were merged into one entity entitled the Division of Community and Family Health (DCFH). Programs were selected for inclusion into DCFH by virtue of their predominant focus and type of activities. Significant administrative and leadership changes accompanied this reorganization. The new leadership, which is supportive of change, has offered MCH the opportunity to step back and do some long needed strategic planning. In addition, the reorganization has identified areas where programs can collaborate.

At approximately the same time, national trends regarding the role of state public health organizations shifted to a strong emphasis on state's assuming responsibility for the core public health functions. The 1988 Institute of Medicine (IOM) Report on the Future of Public Health argues that State public health organizations should have primary responsibility for the core public health functions of assessment, assurance, and policy development. State agencies may focus solely upon these core functions or, depending upon the State infrastructure, may also assume responsibility for providing direct services to citizens. States such as Maine, without sufficient infrastructure to delegate direct services, find themselves assuming the dual role of carrying out core public health functions and providing direct services.

In Maine, the absence of local health departments and county government is further complicated by issues of uneven provider distribution, economic disparity, and a large rural population. All these challenges require the Bureau of Health to provide some direct services in order to ensure statewide public health services access for our most vulnerable populations. We are working to determine the best balance between our dual roles.

Other initiatives impacting the Division include 1993's federal GPRA and Maine's 1997 implementation of Performance-Based Contracting. These initiatives have required a higher level of accountability for both the state and the providers, and as a result, more detailed program reporting requirements. The mandate for more specific data is especially challenging in view of our historical lack of consistent data in many areas. We must obtain and use technology to enhance communication among all stakeholders, and expand our capacity to collect, analyze, and disseminate data.

In 1997 Maine responded to SCHIP by expanding Medicaid and establishing a state operated insurance program for children ages birth through 18 years in families at or below 185% of the federal poverty level (FPL). In October 1999 the eligibility level was increased to 200% of FPL.

None of these new mandates were accompanied by an increase in staff or resources. In fact, the Bureau of Health has experienced decreases in staffing levels while simultaneously increasing the overall number of programs. This inability to hire new staff is directly related to the Executive Branch's mandate not to increase the size of state government. This has resulted in existing staff assuming additional

responsibilities in addition to their already full-time work loads. It has required a dedicated staff to be creative about accomplishing goals with scare resources. Fortunately, DCFH has been able to optimize the talents of a diverse and well-educated staff who have expertise in a variety of MCH programs. Many staff members are long-time employees and know how to work effectively within the confines of state government.

This increase in duties and responsibilities has made us all aware of the need to collaborate and partner with other entities i.e. Department of Mental Health/Mental Retardation/Substance Abuse Services, Department of Education, Department of Environmental Protection (Lead Poisoning), and The Children's Cabinet. We believe MCH can be a leader in facilitating a comprehensive, state-wide coordination of services and funding streams. We must provide services in a more holistic view of the family to ensure the best utilization of scare resources. In order to do this, we must build multi-disciplinary teams. Through Integrated Case Management and other initiatives we must identify and tap funding sources and grants. MCH must also continually evaluate our existing programs for quality and effectiveness. Programs that effectively address the health care needs of Maine citizens must be supported and recognized. Persistent and emerging health issues affecting women and children will require new approaches and modifications to existing programs.

Impact of Welfare Reform on Women and Children

Welfare reform has resulted in a decrease in Temporary Assistance for Needy Families (TANF) caseloads from a high of 19,632 cases in January 1996 to a low of 13, 946 in November 1998. We have also seen the transition of 15,813 individuals to work through the TANF Program.

The advent of Title XXI, SCHIP in 1997 instigated changes in insurance coverage in Maine. Maine responded by expanding Medicaid and creating CubCare, a Medicaid-like Child Health Insurance Program (CHIP). This state operated insurance program for children, which includes EPSDT, is for ages birth through 18 years in families between 150% and 185% of the federal poverty level. In October 1999 the eligibility level was increased to 200% FPL. There is some cost-sharing for the CubCare Program. Outreach activities have resulted in an increase in Medicaid enrollment to a current maximum of approximately 162,000. There are 27.5% (82,415) children ages 0-17 participating in Medicaid. Exact CHIP enrollment figures are unavailable, however, the Bureau of Medical Services (BMS) has recently completed a telephone survey similar to a previous Mathematica survey to assess current insurance coverage for Maine citizens. Final results are pending.

Expansion of Medicaid and CubCare not-withstanding, there are still serious concerns about the changing composition of our uninsured populations. In addition to the traditional numbers of uninsured working poor, there is a growing number of middle-income earners who cannot afford the escalating cost of premium co-pays required for dependent coverage. In addition, national data has shown a disturbing decrease in Medicaid enrollment associated with the change to TANF and the unlinking of TANF and Medicaid.

Following the submission and acceptance of the 1156-"b" waiver, all fee-for-service is being phased out and managed care phased in. Services are offered through BMS via their PrimeCare System, our state run Medicaid managed care (point-of-service) program. A small portion of Medicaid is managed through the MCO, NylCare. NylCare entered the market in 1997 but it's share of coverage accounts for less than 2,000 enrollees and is limited to 7 communities.

In 1999 PrimeCare began expanding beyond the original three pilot counties. The current unduplicated count shows 55,000 insured through Medicaid are enrolled with a Primary Care Provider (PCP) via PrimeCare. By 2001the Bureau of Medical Services plans for all residents in all counties insured through Medicaid to be enrolled in PrimeCare.

There has been minimal managed care penetration within our state. What does exist is primarily in the southern region near Portland. Difficulty establishing networks of providers and services is probably a significant factor in limiting HMO market penetration. The Maine Bureau of Insurance reported in March 2000 that all but one of Maine's HMO's were operating at a loss. HMO Maine (operated by Blue Cross/Shield of Maine) lost $13.2 million in 1999, nearly twice its loss in 1998. Blue Cross posted an overall loss in 1999 of $17.3 million and attributed this loss to Y2K computer spending and greater than expected increases in medical expenses. Aetna U.S. Healthcare and Cigna-HealthSource (previously Health Source) narrowed their losses in 1999 while Harvard Pilgrim was placed in receivership. Tufts Health Plan of New England left the state following heavy losses. Partners Health Plan of Portland continued losses even though membership almost doubled. Only its counterpart in Lewiston, Central Maine Partners Health Plan, showed a small profit. Both of the Partners plans are new, for-profit subsidiaries of Blue Cross jointly owned with Central Maine Medical Center and Maine Medical Center.

Statewide Health Care Delivery System

County & Local Health Departments

Maine's rural nature and town meeting format of local government essentially preclude any significant County government structure or influence. Most public health functions are concentrated at the state level with minimal staffing and funding. The three largest cities maintain local health departments, however, there are no other health departments in Maine outside these cities. The local public health presence is provided by the Bureau of Health's Public Health Nurses, health engineers and restaurant inspectors.

The State's capacity to perform many categorical public health functions is extended through contracts with private health agencies; i.e. home health agencies; hospitals; rural health centers; and private physicians. Contracted Maternal Child Health (MCH) services include community health nursing services; family planning services; adolescent pregnancy and parenting programs; school-based health centers; and specialty clinics for Children with Special Health Care Needs.

Primary Care

Maine has two primary referral centers for health care needs: Maine Medical Center in Portland and Eastern Maine Medical Center in Bangor. In addition there are 36 acute care hospitals (34 are birth hospitals with obstetrical services); 23 federally funded community health centers; 3 Indian Health Service funded health centers on the Reservations; and one small osteopathic medical school. There are no allopathic medical schools in Maine.

Since 1985 the federal Primary Care Program, through the State Loan Repayment Program, has brought 16 primary care physicians, 10 physician assistants, 6 nurse practitioners, 2 nurse midwives, and 2 dentists to Maine. In addition, there are approximately 19 physicians (primary care and psychiatrists) plus 6 physician assistants, 5 nurse practitioners, and 2 dentists serving their National Health Service Corps obligations in Maine. Within the past year (1999), 31 physician applications have been processed by Maine's Office of Primary Care through the Federal J1 Visa Waiver program. Approval of these applications permits these physicians to practice in Maine.

Prenatal Care

Efforts to improve maternal and infant status in Maine are complicated by our geography and population distribution. Multiple services are available locally prior to the occurrence of a *normal* pregnancy and continue through the postpartum period for women and through the first year for infants. However, our high-risk services are located in our three largest cities: Portland, Bangor, and Lewiston. Level III Facilities are located in Portland and Bangor. A Level II facility is located in Lewiston.

The Women and Children's Preventive Health Services program manages a grant with Maine Medical Center for the provision of perinatal outreach which includes education of providers and consumers regarding issues pertinent to pregnancy outcomes. During FY90**,** the perinatal outreach coordinator and other professionals provided 88 educational opportunities attended by a total of 990 providers. Topics included: basic and advanced fetal monitoring; obstetrical emergencies; violence against women; and breastfeeding. We continue to work on formation of a Maternal & Infant Mortality Review (MIMR) to monitor/improve outcomes and education.

High-Risk Care

A small portion of this grant funds the 24-hour statewide availability of perinatology and neonatology consults for providers.

Great care is taken to transport high-risk pregnant mothers to the appropriate facility prior to delivery. However, in the event this is not possible, or an infant is born with unexpected complications, both Level III facilities facilitate transport via provision of a specially trained and equipped neonatal transport team utilizing both air and ground transport.

Birth Defects

The Maine Genetics Program established a CDC Cooperative Agreement to develop and implement a state-based birth defects surveillance program. Year 1 will encompass 2/99-1/00. Case reports are expected to begin by the end of CY2000.

Three workgroups met to discuss various aspects of the Maine Birth Defects Program. Recommendations were received regarding data to be gathered and data sources, reporting mechanism and resources to be developed. An Advisory Committee was formed and a meeting was held December 13, 1999.

A Birth Defects Conference was held September 30, 1999 in Portland November 15 in Bangor and October 14 in Presque Isle. The purpose of this conference was to discuss the emerging Birth Defects Program and the anticipated role of hospitals and providers. The agenda also included information on each of the conditions proposed to be included in the surveillance system once reporting begins. Panel discussions included identifying resources for children with birth defects and a panel with families discussing their experiences with diagnosis and services.

Pediatric Services

Pediatric services are provided by pediatric and family practice physicians as well as pediatric and family nurse practitioners and physician assistants. There is significant variation in distribution of providers across the state, ranging from a low of 33 primary care providers in Aroostook County to a high of 158 in Cumberland County. There are 631 Nurse Practitioners licensed in Maine but the Board of Nursing is unable to report on practice location.

CSHCN Services

During FY98 we estimate the population of Children with Special Health Care Needs in Maine to be 53,913. This figure is calculated based on the 1998 State Census Data on Children Less than 18 Years of Age as reported in the 1999 Maine's Kid's Count report utilizing the 18% prevalence rate for CSHCN suggested by Dr. Paul Newacheck.

In SFY99 the CSHCN Program provided payment of services to 424 Children with Special Health Care Needs who were either uninsured or underinsured. These services required prior authorization and may include — but are not limited to— the following: physician visits, tests, hospitalization, surgery, medications, clinic visits, durable medical equipment and home health services and support.

Maine's Access to Dental Care

Sixteen areas and two state mental health facilities in Maine have been federally designated as Dental Health Professional Shortage Areas. Four additional areas and a third mental health facility have been submitted for designation. Nine of Maine's 16 counties had resident to dentist ratios that were "worse than average" for the state.

Access to regular oral health care for many people in Maine, particularly low income and Medicaid-eligible children and adults, remains a neglected and fragmented part of general health care. Fewer than half of Maine's actively practicing dentists are treating Medicaid patients, and 80% of billings are coming from 15% to 20% of providers.

Mental Health Services

The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is responsible for addressing the mental health needs of Maine's citizens. They have seven regional centers. This department also provides Medicaid behavioral care services. There is an increasing issue of lack of access to mental health services.

State MCH Priorities

The Division of Community and Family Health has made a long-term commitment to improving the health outcomes of Maine's citizens. During FY00 the MCH program developed a strategic plan with the vision of a Maine where all individuals, families, and communities enjoy optimal health and quality of life. Attention to five priority areas for focusing our human and financial resources is critical to achieving this vision. These areas are:

1) Building systems and community capacities
2) Initiating and advocating for public health policy
3) Developing and delivering programs and services
4) Collaborating with others
5) Providing leadership

The above are global organizational priorities strive to strengthen our infrastructure and will be integrated throughout our MCH programs. As a result of our strategic planning and needs assessment activities, the following five focused and more readily measured priorities have also been identified. These reflect our efforts to move toward less categorical and more core public health functions. They are as follows:

6) Establish the Maternal and Child Health Advisory Committee
7) Improve nutrition and physical activity for the MCH population
8) Enhance teen health initiatives and programs
9) Integrate MCH activities with tobacco cessation and prevention activities.
10) Coordinate across Programs and Divisions on common issues

In addition, as noted on page 120 of this document, we have identified additional specific priorities based on stakeholder input.

Historically, Maine's state negotiated performance measures have directly aligned with the state MCH priorities. It is important to note the original state negotiated measures no longer align so clearly with our new priorities and must be reviewed. During the drafting of our initial state performance measures the benefit of epidemiological expertise and input was clearly demonstrated to us. Therefore, we have decided to postpone revision or creation of new state performance measures pending the availability of MCH

epidemiologic personnel. We have allocated SSDI funds for a Master's prepared MCH epidemiologist and have recently received support from the Council of State and Territorial Epidemiologists (CSTE) for a Ph.D. prepared MCH epidemiologist. Searches for these two positions are currently underway.

1.5 State Title V Agency (see Figures 1,2, and 3)

The State Title V Agency in Maine is the Maine Department of Human Services (DHS). Administrative oversight of the Maternal and Child Health Services Block Grant is vested with DHS's Bureau of Health (BOH). Specifically, the day-to-day management of the MCH Block Grant is carried out in BOH's Division of Community & Family Health (DCFH). This Division is further sub-divided into two sections: Community Health Programs and Family Health Programs. The Community Health section houses primarily population-based prevention and health promotion services while the Family Health section houses the Division's direct service programs.

Kevin Concannon is Commissioner of Maine's Department of Human Services and reports directly to Governor Angus S. King, Jr.. Dora Anne Mills, M.D., M.P.H. serves as Director of the Bureau of Health. Randy Schwartz, M.S.P.H. is Director of the Division of Community and Family Health. Valerie Ricker, M.S.N., M.S., N.P. is Director of the Family Health section as well as Director of Public Health Nursing. Barbara Leonard, M.P.H. is the Director of the Community Health section in addition to her duties as the Director of the Breast & Cervical Health Program. Fredericka Wolman, MD, MPH is the MCH Medical Director for the Division.

The MCH leadership has clinical training and expertise. They maintain membership with their respective professional organizations i.e. Maine Nurse Practitioner Association, Maine Chapter of American Academy of Pediatrics, and North East Rural Pediatric Association ensuring an ongoing relationship with primary care providers. Several MCH personnel are also involved in statewide initiatives that involve primary care.

Org Chart 1

Org Chart 2

Org Chart 3

1.5.1 The State Agency Capacity

The purpose of Maine's Bureau of Health is " to preserve, protect, and promote the health and well-being of the population through the organization and delivery of services designed to reduce the risk of disease by (1) modifying physiological and behavioral characteristics of population groups; (2) controlling environmental hazards to human health; and (3) promoting health and wellness through education, counseling, and access to health services."

The purpose of the Division of Community & Family Health is to promote health and prevent disease, injury and disability through a variety of public health interventions ranging from primary prevention through broad-based community health promotion initiatives, early detection, health systems interventions, delivery of health services and the promotion of healthy public policies. The Division's vision is "that individuals, families and communities in Maine will achieve and sustain optimal health and quality of life".

Family Health promotes health and wellness and enhances the quality of life for individuals, families and communities through:

- Building systems and community capacities.
- Initiating and advocating for public health policy.
- Developing and delivering programs and services.
- Collaborating with others.
- Providing leadership.

Maine Department of Human Services, Bureau of Health, Vision Statement.

1.5.1.1 Organizational Structure (See Figure 4)

We are part of a growing national trend to re-evaluate the role of public health policy and programs in state systems and infrastructure. This includes movement of state agencies away from direct service toward an increased focus on the core public health functions of assessment, quality assurance, and policy development. As a result of this changing environment, we are using the five-year planning process as an opportunity to step back and reassess our overall direction. Because we must continue to be the "safety net" and provide direct services for some of our most vulnerable citizens, changes in program focus and activities must be done with great care and forethought. This will be a multi-year process, requiring transitioning of resource allocations from traditional to current and emerging priorities.

1.5.1.2 Program Capacity

Table 1: Title V Funded Programs for Pregnant Women, Mothers & Infants

Preventive & Primary Care Services	
Program	**Description**
Childhood Lead Poisoning Prevention Program Program Manager: MaryAnn Amrich 4 FTE's* 1 FTE via contract	Provides lead testing services and lead poisoning prevention activities across the state, including the MCH population. Primarily funded via the CDC. Only $35K is from MCH Block Grant which is used for lead testing. Starting 8/14/00 2 positions will be paid from general funds
Children with Special Health Care Needs Program (CSHCN) Program Manager: Toni Wall, BS 10 FTEs*	The mission of the Children with Special Health Care Needs Program is to improve the health and quality of life of infants, children and adolescents with special health care needs. Program activities include: • Payment of sub-specialty medical treatment, including diagnostic, medical, surgical, corrective and other therapeutic interventions • Coordination of care and referral services to families of children with special health needs regardless of income • Administer the Cleft Palate Clinic and the Southern Maine PKU/Metabolism Clinic • Fund two Spina Bifida Clinics, two Pediatric Oncology Clinics, and five Developmental Evaluation Clinics
Genetics Program Program Manager: Ellie Mulcahy, RNC. 2 FTEs* *Note*: 1 FTE will be added 12/00 (Comprehensive Health Planner I) to work with the new Birth Defects Surveillance Program.	The Genetics Program is legislatively mandated. The overall goal is to assure Maine individuals and families access to comprehensive genetic services enabling them to make informed choices and increase their ability to live healthy and productive lives. The Program provides genetic services for Maine families who are at risk for genetic conditions via referrals to genetic agencies. It administers the mandatory screening of all infants born in Maine for conditions which, if left untreated, would cause mental retardation, health problems or death. The Genetics Program is beginning to examine the impact of birth defects and other genetic conditions and ensure access to services through the development of a birth defects registry. The program has a cooperative agreement (1999-2002) with the CDC to develop and implement a state-based birth defects surveillance system.

Note:
All FTE's are total employees within the Programs, including professional and clerical positions.

Preventive & Primary Care Services	
Program	**Description**
Healthy Families/Home Visitation Programs Program Manager: Jacqueline Roberson, B.S.N. 1 FTE* *Note:* One additional FTE (Planning and Research Associate) will be added in 10/00 along with a .5FTE Clerk Typist.	Healthy Families is a nation wide program by Prevent Child Abuse America that seeks to ensure healthy children and to nurture families by offering short and long term home-based support and assistance. Services are initiated prenatally (or at birth) and may continue for 5 years. Participation by Maine families is voluntary. Program goals are to systematically assess family strengths and needs, to enhance family functioning, to promote positive parent-child interaction and to promote healthy childhood growth and development.
Maine Injury Prevention Program (MIPP)* * formerly the Childhood Injury Prevention & Control Program Program Manager Intentional Injury Prevention: Cheryl M. DiCara, BSW Program Manager Unintentional Injury Prevention, Diane Arbour, BA 8 FTEs*	The MIPP is organized to address intentional and unintentional injuries. The mission of the MIPP is to ensure that Maine citizens of all ages have the knowledge, skills and access to resources that keep youth, less than 24 years of age, safe from injuries. Our priority is to reduce serious and fatal injuries with subsequent reduction of associated healthcare costs via collaborative efforts with national, state and local organizations. We seek to build a state level injury prevention infrastructure which provides leadership for public health education, professional training, and policy issues; offers technical assistance regarding injury prevention program development/implementation/evaluation; collects and analyzes data to monitor and direct program efforts; and funds community-based interventions.
Maternal Child Health Nutrition Program Program Manager: Janet Leiter, MS, RD, LD 1 FTE*	The MCH Nutrition Program promotes good nutrition and healthy lifestyles for Maine's MCH populations. Through coordination with other nutrition-focused entities, the Nutrition Program ensures that the MCH populations have access to comprehensive services, which are scientifically sound and culturally sensitive.

Note:
All FTE's are total employees within the Programs, including professional and clerical positions.

Preventive & Primary Care Services	
Program	**Description**
Oral Health Program (OHP) Program Manager: Judith A. Feinstein, MSPH. 4 FTEs*	The mission of the Oral Health Program is to improve the oral health of Maine people through: • Public leadership to enable communities to prevent, control and reduce oral diseases; • Planning, implementing and evaluating programs for oral health promotion and disease prevention; • Statewide coordination and integration of community-based oral health services through increased access and removal of barriers. The mission is accomplished through three approaches: 1) Community Prevention Services 2) Planning and Assessment Services 3) Community and Professional Education and Training Services
Public Health Nursing (PHN) Program Manager: Valerie Ricker, M.S.N. M.S. N.P. 67 FTEs * (60 R.N.s and 7 clerks) **Valerie has multiple roles and responsibilities beyond this program.*	This program is staffed by professional registered nurses serving communities across Maine. They assist families and communities to prevent and control communicable diseases, obtain specialty care, and care for the sick, assist Children with Special Health Care Needs to access services, and support families in stress. The PHNs perform services related to health assessment, health education, health counseling, health promotion and disease prevention. Services are available to all people in Maine and are provided through home visitation, well child clinics, school-based health services to small rural schools, specialty clinics, and community education events.
SSDI Project: Project Director: Valerie Ricker, M.S.N., M.S. 1 FTE * allocated *Valerie has multiple roles and responsibilities beyond this program.* *Note*: Upon hiring a Master's prepared epidemiologist the program will have one additional FTE.	The overarching goal for the State Systems Development Initiative (SSDI) project is to build the epidemiology and data capacity within the MCH related programs, and to improve the way data is utilized by program managers and service providers.

Note:
All FTE's are total employees within the Programs, including professional and clerical positions.

Preventive & Primary Care Services	
Program	**Description**
Teen and Young Adult Health (TYAH) Program Manager: Nancy Birkhimer, MPH. 3 Full Time Equivalents* (FTEs)	The Teen and Young Adult Health Program assures that all adolescents have access to support systems, services, information and skills that promote healthy life choices. We accomplish this by a variety of activities including: coordination and collaboration with other State programs that include adolescents in their target populations; funding and support to school-based health centers; adolescent pregnancy and parenting projects; reproductive health services; technical assistance; advocacy, and support to agencies and organizations that strive to improve the health status of adolescents.
Women & Children's' Preventive Health Services (WCPHS) Acting Program Manager: Valerie Ricker, M.S.N., M.S. 1 FTE* allocated *Stating there is 1 FTE is inaccurate because Valerie has multiple roles and responsibilities beyond this program.*	The Women's and Children's Preventive Health Services (WCPHS) program addresses health promotion/disease prevention issues in pregnant and postpartum women, infants and children ages 0-21. The program goals are to assure the availability, accessibility and appropriateness of health care information and services that target this population, and to assure that services meet clinical standards of care. The priority health status indicators for the WCPHS Program are reductions in: • infant mortality • prenatal risk factors • risks of labor and childbirth • poor childhood outcomes
Women, Infants, Children (WIC) Program Manager: Ron Bansmer, MBA 9 FTEs*	The WIC Program provides specific nutritious foods and nutrition education to low income child bearing women, infants, and young children who are at medical or nutritional risk. It is an adjunct to health care and provides supplemental foods during critical times of growth and development. The WIC Program has also developed a number of collaborative relationships with many MCH and non-MCH programs. Frequent referrals are made between these programs. An on-going priority is to work with the Family Health Programs to develop a broader, stronger, network of support for breastfeeding women.

Note:
All FTE's are total employees within the Programs, including professional and clerical positions.

1.5.1.3 Other Capacity

MCH Staff:

The majority of the MCH Title V program staff are centrally located in Augusta, our State Capital. Staff classifications include: clerical support, health planners, planning and research assistants, health educators, program managers, accountants, and MCH medical and administrative senior managers. Title V also funds 5 positions outside the Division of Community & Family Health: one person in the Office of Data, Research & Vital Statistics; 2 in the Health & Environmental Testing Laboratory (support lead testing, sexually transmitted disease testing, etc.); and 2 in the Department of Education (work with schools to develop and utilize comprehensive health education curriculums). All of these positions contribute to the achievement of MCH priorities.

In addition, Title V partially supports 57 Public Health Nurses (5 supervisors and 52 field nurses) who are based statewide in 17 regional satellite offices. These nurses provide direct services via home visits, school health, immunizations, well child and specialty clinics, and participate in our program planning/evaluation. The Title V Program also has an agreement with the University of Southern Maine's Muskie School of Public Service for assistance with strategic planning and training.

Please refer to DCFH senior management biographies, Section V Supporting Documents.

Recent Legislation:1.5.1.4 (Table 2)

Legislation	Description
LD365 "Conflict Resolution Model"	This Resolve Chapter 19-1997 led to the establishment of a study commission on youth violence. The "Commission to Study Providing Educators with More Authority to Remove Violent Students From Educational Setting met throughout fiscal year 1998 and made several recommendations that impact the work of the MIPP. These recommendations included a requirement that all school administrative districts develop and implement a crisis response plan for each school in the district. As part of the MIPP youth suicide and violence prevention activities, and in coordination with the Departments of Education; Mental Health, Mental Retardation and Substance Abuse; Maine School Management Association and others, MIPP staff provided training on school-based crisis intervention. Other recommendations included expansion of Conflict Resolution (CR) and Peer Mediation (PM) programs. In FY 99 the legislative task force continues to meet to address youth violence issues and identification of alternatives for disruptive students.
LD1543 "An Act to Create a Bicycle Safety Education Act"	Under this act, persons under the age of 16 years, operating a bicycle or riding in a bicycle seat or trailer on a public road or path must wear a properly fitting bicycle helmet. A person in the business of renting bicycles must post a notice and alert bicycle renters to a written notice of this law. The law requires any business renting bicycles to provide a helmet to any operator or passenger under the age of 16 years. There is no enforcement component to this law, however at their discretion a law enforcement officer may provide education to the child and parents.

LD 1905 "An Act to Establish the Birth Defects Monitoring Program"	The Maine Legislature passed this law in 1999 to establish a statewide surveillance and services program. This law authorizes the Genetics Program to require hospitals and providers to report the occurrence of birth defects, allows program access to medical records and other information, and allows the program to contact families to provide information about resources and services.
LD 1755, passed as PL 1999, Ch. 310 "Oral Health Studies"	Called for authorized three studies: one concerning the use of mobile units/dental vans to provide certain dental services in remote or under served areas; one evaluating the feasibility of establishing a dental residency program in Maine; and the third was a review of reimbursement rates in the Medicaid program, including an assessment of the feasibility of additional reimbursement for high volume providers. The first two studies were assigned to DHS; the residency study was the responsibility of the Finance Authority of Maine. Oral Health Program staff participated in an advisory committee on the latter, and have primary responsibility for the mobile van study report, which is still pending. The other two reports were completed in December 1999.
LD 1965, passed as PL 1999, Ch. 496 "Maine Dental Loan Repayment"	Authorized the Maine Dental Loan Repayment Program. This is a loan repayment/forgiveness program either for newly licensed dentists or dental school students requiring recipients to agree to practice in a state-designated under served area on a year-for-year basis. One loan was authorized for SFY2000 using state general fund money; three were authorized for SFY01 to be funded with tobacco settlement money. Oral Health Program staff participated in the development of the proposal through the Maine Dental Access Coalition. The enabling statute created an Advisory Committee on Dental Education and names a representative of the OHP as a member.
LD 2099, "An Act to Provide Increased Access to Dental Care in Maine"	This new "Dental Services" program authorized $1 million using tobacco settlement funds beginning July 1, 2000. It provides funds to assist non-profit community-based dental centers with start-up costs, offset/subsidize sliding fee scales, and case management and community education services. The OHP will have major administrative responsibility for the program. Up to $250,000 will be available for public and private non-profit organizations to develop and expand oral health care programs; $50,000 is allocated for case management and community oral health education; up to $650,000 is allocated for subsidies to programs providing clinical dental services to offset their sliding fee scales up to the level reimbursed by Medicaid. Funds are expected to be contracted by the end of the calendar year 2000. The remaining $50,000 goes to the Medicaid agency for targeted Medicaid case management.

LD956 "resolve to Implement the Recommendations of the Task Force to Study Strategies to Support parents as children's First Teachers:	Under this resolve, the "Parents as Children's First Teachers" recommendations to expand support and education to newborns and their families are to be implemented. DHS is charged with responsibility to monitor and support the development of home visiting programs. In FY00, money from Maine's Tobacco Settlement was appropriated to implement expansion of home visiting programs.
LD474"Jake's Law" entitled "An Act Related to the Crime of Murder and the Murder of Children"	This law was introduced by a parent whose four-month-old son was the victim of SBS. This law was passed in the January 2000 legislative session. Specifically it requires that the murder of a child less than six years of age be a special consideration in sentencing.

1.5.2 State Agency Coordination/Key Title V Relationships

State Agencies and Committees/Cabinets

- The Department of Mental Health, Mental Retardation & Substance Abuse Services
- The Department of Education
- The Bureau of Medical Services
- The Bureau of Elder & Adult Services
- The Children's Cabinet
- The Children's Policy Committee
- The Children's Death and Serious Injury Review Committee
- The Early Care and Education Task Force
- The Child Abuse Action Network
- Youth Suicide Prevention Advisory Committee
- Integrated Case Management Committee
- Coordinated School Health Advisory Committee
- Partnership for a Tobacco-Free Maine
- EPSDT Advisory Committee
- Childhood Lead Poisoning Prevention Advisory Committee

Locally and Federally Funded Agencies & Health Centers

- Region I Women's Health Workgroup
- New England Serve
- Federally Qualified Health Centers

Associations & Organizations

- American Academy Pediatricians, Maine Chapter
- American Lung Association
- Natural Resources Council of Maine
- American Public Health Association(APHA)
- Association of Maternal & Child Health Programs
- Maine Center for Public Health
- Community Action Program
- Family Voices
- March of Dimes
- Maine Health Information Center
- Maine Medical Assessment Foundation
- Maine Public Health Association
- Medical Care Development
- Membership in the following affiliates of the Association of State and Territorial Directors: Nursing, Dental, Public Health Nutrition, and Injury Prevention
- Turning Points
- NECON

Tertiary Care Facilities

Eastern Maine Medical Center

Maine Medical Center

Universities

University of Southern Maine (Muskie School of Public Service and Nursing Program)

University of Maine (Orono and Farmington campuses)

University of New England Osteopathic School

II. REQUIREMENTS OF THE ANNUAL REPORT

2.1 Annual Expenditures

No narrative. See Forms 3 (SD page #); 4 (SD page#); 5 (SD page #) and the ERP pages (page #)

2.2 Annual Number of Individuals Served

No narrative. See Forms 6 (SD page#) 7 (SDpage #); 8 (SDpage #); 9 (SD page #); and the ERP (page #)

2.3 State Summary Profile

No narrative. See form 10 (SD page #) and the ERP (page #)

2.4 Progress on Annual Performance Measures

2.4.1 Description of Report Format

In Section 2.4.2 we present graphics of the MCH Pyramid and of the Title V Block Grant Performance Measurement System Model (Maine for 1999). This model will not reflect our new priorities until we have revised our existing state negotiated performance measures and/or developed new state negotiated performance measures with the assistance of our epidemiologists. In section 2.4.3 is a matrix of our specific program activities by population (1) pregnant women, mother and infants; (2) children and adolescents; and (3) Children with Special Health Care Needs. These lists are further subdivided into four main categories corresponding to each level of the federal Core Public Health Services Pyramid: (a) Direct Services (b) Enabling Services (c) Population-based Services and (d) Infrastructure Building Services. We do not discuss these activities in this section. Instead, the detailed discussion of each program activity follows in Section 2.4.4, relating program activities to the most closely associated federal performance measure/outcome. The Federal and corresponding state performance goals are listed at the top of the page. The MCH service pyramid level, type of performance measure, and population(s) served are noted with small graphics

We reorganized our report narrative, incorporating suggestions from our federal reviewers, because we believe this format eliminates repetition and makes it easier for our diverse readership to understand the inter-relatedness of Maine's goals and activities and their relationship to the federal performance measures/outcomes. Section 2.5 reports Outcome Measures.

This document presents an assessment and description of Maine state services available to each of these groups. No one agent provides complete services for any particular population or age grouping because many of our programs provide a variety of interventions across populations.

All vital statistics data and the majority of other data are reported by calendar year (CY). This report represents CY 98. Maine State fiscal year (SFY) runs July 01 through June 30. This report will focus on state fiscal year 1999 unless otherwise noted as FFY, which refers to federal fiscal year. Program specific data is presented in a manner consistent with national standards. Specifically, data presented may represent different aggregates of year. Care has been taken to identify these statistical variations where they occur.

2.4.2.1 MCH Pyramid

2.4.3 Matrix (Table 3)

Maine Title V Activities by Level of the Pyramid for MCH Populations

	Pregnant Women, Mothers & Infants	***Children & Adolescents***	***Children with Special Health Care Needs***
Infrastructure Building Services *Programs and activities to develop, support and maintain access and quality services.*	MCH Collaboration with WIC Program The Women and Children's Preventive Health Services PHN/CHN Shaken Baby Education Program Peri-natal Outreach Maternal & Infant Mortality Reviews Genetics Program Healthy Families Program Chronic Disease & MCH Epidemiology Evaluation Capacity Building	Maine Dental Access Coalition Oral Health Consultation & Technical Assistance School Oral Health Program School-Based Health Centers Public Health Nursing Well-Child Clinics Lead Screening Program PHN/CHN Fire Safety Youth Suicide Prevention Youth Violence Prevention Child & Youth Injury Prevention Child Traffic Safety Abuse and Neglect "Healthy and Ready to Work" Child Fatality Reviews MCH Nutrition Healthy Families Program Chronic Disease & MCH Epidemiology Evaluation Capacity Building	On-line Resource for CSHCN Family Advisory Council Genetics Program Birth Defects Program Chronic Disease & MCH Epidemiology Evaluation Capacity Building

	Pregnant Women, Mothers & Infants	***Children & Adolescents***	***Children with Special Health Care Needs***
Population Based Services *Preventive and Personal health services available to all Maine mothers and infants*	The Newborn Screening Program PHN/CHN Nursing Referrals Breastfeeding Programs Newborn Hearing Screening Infant Mortality Review Healthy Family Referrals Perinatal Outreach (Maine Medical Center) SIDS Program Maine's Multi-disciplinary Review Panel on Child Death & Serious Injury Due to Abuse and Neglect Shaken Baby Education Program Child Traffic Safety Family Planning Services Oral Health Grants Preventive Dental Program in WIC School Oral Health Program	Child Traffic Safety Fire Safety Youth Suicide/Violence/Injury Prevention Activities Primary Adolescent Pregnancy Prevention Program Peer Leader Project Oral Health Grants School Oral Health Program	6 Regional Outreach Workshops on Cleft Palate/Lip CSHCN Occupational Therapist
Enabling Services *Assist eligible Maine citizens to access health care, health information and health services.*	MCH collaboration with WIC Lead Screening Program Breastfeeding Support Services Adolescent Pregnancy & Parenting Projects Healthy Families Program	Teen Family Planning Services Adolescent Pregnancy & Parenting Projects School-based Health Centers Health Education Resource Collection Maine's Dental Clinics Oral Health Promotional Materials Oral Injury Prevention Child Traffic Safety Fire Safety Youth Suicide Prevention Healthy Families Program	PKU Education & Support Family Support Services CSHCN collaboration with WIC Program (special formulas) Healthy Families Program

	Pregnant Women, Mothers & Infants	***Children & Adolescents***	***Children with Special Health Care Needs***
Direct Health Care Services Personal care services	Public Health Nurses/Community Health Nurses (PHN/CHN) Genetics Program Healthy Families Program	PHN/CHN Genetics Program Immunizations Well Child Clinics Teen Family Planning Services Dental Sealants Healthy Families Program	Cleft Palate Clinics Public Health Nursing Cleft Lip/Palate Resource Group Spina Bifida Clinic Care Coordination Services Developmental Evaluation Clinics Maine Children's Cancer Program Southern ME PKU-Metabolism Program MCH Nutrition Program On-Line Resource "Healthy and Ready to Work Initiative" Maine's Adolescent Transition Partnership Public Health Nurses/Community Health Nurses CSHCN Program for 3rd Party Payment for Special Medical Services Genetics Services Healthy Families Program

Section 2.4.4

Federal Performance Measure #1

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

State Specific Performance Measure # 6

The % of percent of Children with Special Health Care Needs.

Pyramid Level: ▲ Direct △ Enabling △ Population-based △ Infrastructure

Type of Measure: ■ Capacity ☐ Risk Factor ☐ Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ☐ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #1 and State Performance Measure # 6

Review SSI Reports and enroll eligible children

As of December 1999, the Social Security Administration, Office of Research Evaluation and Statistics, reported that Maine had 2,720 children under the age of 16 receiving federally administered SSI payments. (Note: An additional 170 children aged 17 years received services also.) The CSHCN Program served 206 children or 7.6%. This is a decrease from the previous year of 9.4%. The decrease in percent served is due in part to the increase in the number of children under the age of 16 years receiving federally administered SSI payments.

The State's Disability Determination Unit routinely refers children who apply for SSI payments to the CSHCN Program for further assistance. The CSHCN Medical Consultant reviews SSI medical reports, and those children that are deemed medically eligible are sent an application for CSHCN Program services. Eligible medical conditions are those conditions which restrict functioning or cause developmental delays, require a level of health care beyond routine/basic care, require pediatric specialty care for an extended period of time and can be maintained or improved by such treatment and services. The CSHCN Program assists these children by providing care coordination, mileage and lodging reimbursement, and other appropriate services not covered by the Maine Medicaid Program.

Federal Performance Measure #2

The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty/subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Pyramid Level: ▲ Direct △ Enabling △ Population-based △ Infrastructure

Type of Measure: ■ Capacity ☐ Risk Factor ☐Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ☐ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #2

CSHCN Payment of Services

In FFY99, the CSHCN Program provided payment of services to 424 children with special health needs who were either uninsured or underinsured. These services require prior authorization and may include—but are not limited to—the following: physician and clinic visits, laboratory analysis, inpatient/outpatient hospitalizations, medications, durable medical equipment, home health services and other support services not otherwise available. Children who are Medicaid eligible and meet the medical eligibility guidelines for the Program may be eligible for payment of services that are not available from the Maine Medicaid Program.

Care Coordination Services

During FY99, care coordination services were provided to 1,324 children. The CSHCN Program defines care coordination as *"services that are provided to ensure the effective and efficient organization of and access to services and resources that are necessary to meet the needs of the individual and his/her family. Care coordination assures timeliness, appropriateness, and completeness of care."* Care coordination services are provided to all program clients and also to clients who access more comprehensively coordinated services through community-based agencies near the family home. These referrals include-public health nursing, child development services, services to children with Special Health Needs, and other agencies as appropriate. Care coordination services are available to all families regardless of their ability to pay for services. As part of the Program's care coordination services, and in an effort to remain family-focused and community-based, we continue to attend early childhood and pupil evaluation team meetings to assist families in developing individual family support plans.

Early Intervention Services

In an effort to develop collaboration with the Department of Education's Early Intervention Services Program, the Director of the CSHCN Program has been asked to serve on the Board of Directors for Southern Kennebec Child Development Services, and the Assistant Director has been asked to serve as the program liaison to the Maine Administrators of Services for Children with Disabilities.

Family Support Services

During FY99, the CSHCN Program provided enabling services to 191 families. Enabling services allow families to access specialized medical care not otherwise available, including lodging and transportation reimbursement.

Spinoza Bear Project

During FY99 the CSHCN Program collaborated with the American Legion to distribute Spinoza Bears to 29 children with special health needs. The Spinoza Company of St. Paul, MN, created the Spinoza "buddy bear project" for children with a life challenging condition or crisis. It is a community-based program designed to help children physically, psychologically and emotionally endure symptoms and procedures that are often painful or frightening. The CSHCN Program obtains permission from the families for their child to receive a bear and then Program staff delivers the bears. During FY99 the CSHCN Program has collaborated with the American Legion to distribute Spinoza Bears to 29 children with special health needs.

The Healthy and Ready to Work Initiative - The Maine Adolescent Transition Partnership (MATP)

The MCHB HRTW initiative was awarded to the CSHCN Program in October 1997 as a planning grant. The CSHCN Program was subsequently awarded a four-year implementation grant in October 1998. The Director of the CSHCN Program is the Project Coordinator and the University of Maine at Orono, Center for Community Inclusion, a University Affiliated Program implements MATP. During FY99 we continued to integrate services and support into an understandable, easily accessible, financially feasible, culturally competent, coordinated system in which all youth with special health care needs are identified and receive the necessary supports to transition into adulthood. This year saw the introduction of the Service Tapestry-a web-based resource directory of all available resources in a specific geographical area. This project continues to collaborate with the following agencies: Department of Education, Department of Mental Health Mental Retardation and Substance Abuse Services, Department of Human Services, other adolescent groups and adolescents.

Youth Conference 2000

In preparation for a Youth Conference 2000 focusing on the transitional needs of 14-18 year olds with special health care needs, we have requested the assistance of youth in the planning process. The youth will plan the conference with guidance from the nurse coordinator of the Myleodysplasia Clinic, MATP members, CSHCN staff and parents. The conference will be held at the University of Maine at Orono and will target 14-18 year olds with special health needs/disabilities and their parents.

CSHCN Interdisciplinary Clinical Services

The CSHCN Program continues to administer and fund many interdisciplinary clinics. These clinics help in the early identification of children with special health needs, provide families with services that are community-

based, offer full or partial team evaluations, and provide a fully developed plan of care designed around the child and family needs. Team members vary from clinic to clinic, but each clinic includes health providers who are experts in their field such as pediatric specialists, public health nurses, nurse coordinators, social workers, physical, occupational and speech/language specialists, psychologists, psychiatrists, dental specialists, special educators, nutritionists, genetic counselors, parent advocates and families. Clinical services are available to individuals regardless of income.

Clinical Services Administered by the CSHCN Program

Southern Maine PKU-Metabolism Clinic

This clinic met five times in Portland and provided services to 25 children and their families during FY99. The rationale behind this clinic is to ensure that children with hereditary metabolic disorders and their families are provided access to frequent and regular team meetings to develop plans of care and monitor growth, development and cognitive ability. This program consists of three components: a multidisciplinary clinic, newborn home and/or hospital visits, and outreach education to schools, day cares and other areas that may provide services to the families. Outreach education is provided by the nurse coordinator and the parent of a child with PKU. The nurse is also an integral part of the clinic team.

Cleft Palate Clinic

During FY99, 126 children were seen at 24 clinics provided in Portland (12) and Bangor (12). The Cleft Palate Clinic is an interdisciplinary team of providers with expertise in cleft lip/palate and other cranio-facial anomalies. This team, along with the family, develops a comprehensive treatment plan which is then implemented at the local level. There are three components to this clinic: multidisciplinary clinics, home and/or hospital visits (includes a feeding assessment) and outreach education. The CSHCN nurse coordinator also attends early childhood and pupil evaluation team meetings to address educational issues. The CSHCN nurse coordinator works closely with the Public Health Nurse Cleft Lip/Palate Core team. This group of specially trained nurses is the CSHCN Program's regional-based experts. The Core Team PHN provides the initial home-based visit with the family and links the family with a public health nurse in their community. This group meets quarterly with the CSHCN Nurse Coordinator, who provides training.

Clinical Services Funded by the CSHCN Program

Myleodysplasia Clinic

During FY99, 85 children with neural tube and other spinal cord lesions made 125 visits to these two hospital-based clinics. The clinics are held at Eastern Maine Medical Center (EMMC) in Bangor and Maine Medical Center (MMC) in Portland. These clinics provide a comprehensive, multidisciplinary approach to meeting the health care needs of infants, children and adolescents by providing case management and coordination, outreach education to schools and day cares, attending early childhood and pupil evaluation team meetings. The CSHCN Family Care

Coordinator continued to attend each clinic, acting as the Program liaison and providing information and resources not otherwise available to families.

Developmental Evaluation Clinics

During FY99 the 5 Developmental Evaluation Clinics saw a total of 331 children ages 0 - 6. An interdisciplinary team with expertise in child development provides a medically based, comprehensive diagnostic assessment for the purpose of confirming a diagnosis and developing a prescriptive treatment plan. Clinics are held at least monthly in Caribou, Bangor, Waterville, Auburn and Portland.

Maine Children's Cancer Program

During FY99, the MCCP provided weekly clinics in Scarborough to 208 children. The MCCP is a comprehensive center providing medical treatment, psychosocial support and clinical research. CSHCHN funds are used to support the MCCP Pediatric Outreach Support Services Program, a unique program that provides a full time triage nurse, an evaluation of in-home care services, pediatric oncology education at schools and other agencies, and social and emotional support to children and families. The CSHCN Program is not able to provide a non-duplicative count at this time as the Management Information System was not designed to calculate this population correctly. This figure has not been added to the overall number of children served by the CSHCN Program.

Eastern Maine Medical Center's Hematology and Oncology Program

During FY99, the EMMC Program provided services to 65 children. The EMMC is a comprehensive center providing medical treatment, psychosocial support and education to children and their families in Northern and Downeast Maine. CSHCN funds are used to support the EMMC Social Worker who provides emotional support to children and their families and outreach education to schools and other agencies serving the child. The CSHCN Program is not able to provide a non-duplicative count at this time as the Management Information System was not designed to calculate this population correctly. This figure has not been added to the overall number of children served by the CSHCN Program.

Cystic Fibrosis Centers

The CSHCN Program provides partial funding to the State's three hospital-based clinics in Portland, Lewiston and Bangor. Information on the number of children served is not available, as we have not required reporting in the past. As of July 2000 (FY01) these sites will be required to report and this data will be available next year.

The Children's (Cerebral Palsy) Center's

The CSHN Program provides partial funding to the State's three hospital-based clinics in Portland, Augusta and Bangor. Information on the number of children served is not available, as we have not required reporting in the past. As of July 2000 (FY01) these sites will be required to report, this data will be available next year.

Federal Performance Measure #3

The % of Children with Special Health Care Needs in the State who have a medical home.

Pyramid Level: ▲ Direct △ Enabling △ Population-based △ Infrastructure

Type of Measure: ■Capacity ☐ Risk Factor ☐Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ☐ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #3

During FY99 the CSHCN Program served 1,324 children through clinics and the CSHCN Program itself. 100% of these children have a medical home. The CSHCN policy requires all children who receive services whether directly through community-based grantee programs or through third party payment services must have a primary care provider who is responsible for the overall care of that child. The CSHCN Program recognizes the American Academy of Pediatrics definition of a "medical home" where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally-competent.

Medical Home	Number of Children
CSHCN Program	923
Developmental Evaluation Clinic	331
Myleodysplasia Clinic	85
Total with a medical home	1324

Table 4

Due to the CSHCN Program's ability to retrieve information on clients so that is non-duplicative, there is an increase in the reported numbers for FY99. The clinics mentioned above are required to have parents complete a client form for each encounter. This form reports insurance status, medical home, and other demographic information that has assisted us in reporting unduplicated counts.

The Maine Children's Cancer Program, Eastern Maine Hematology and Oncology Clinic, Cystic Fibrosis Clinic, and the Children Center's are not included in this count, as the data does not reflect non-duplication of clients. The Maine children's Cancer Center and Eastern Maine Hematology and Oncology Clinics serve 208 and 65 children respectively. This number is not included in the overall count of children with a medical home because some of these children may already be in the CSHCN Program and thus would be counted twice. The CF Clinic and the Children's Center receive funding that is appropriated by the Legislature and funneled through the CSHCN Program. To date we have not required them to report the number of children they serve. During FY01 they will be required to report to our Program how many children accessed their services.

Federal Performance Measure #4

% of newborns in the State with at least one screening for each of PKU, hypothyroidism, galatosemia, hemoglobinapathies.

State Performance Measure #7

Timely provision of genetics services.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

Populations Served: ■ Pregnant Women, Mothers & Infants ☐ Children ☐ CSHCN

Program & Activities Contributing to Success of FPM #4 and State Performance Measure #7

The Newborn Screening Program

Maine screened 13,541 infants in Calendar Year 1998 (CY98). This resulted in 99% of our infants being screened. The percent of newborns in the State with at least one screening each for PKU, hypthyroidism, galactosemia, hemoglobinopathies was calculated based on the 13,685 occurant births in Maine. Infants not screened included infants whose parents held religious objections to testing or infants who died early in the neonatal period.

The Genetics Program is involved in referring infants who have a confirmed positive newborn screen to specialists for confirmation and treatment. During CY98, 100% of newborns (6) with confirmed positives were receiving appropriate treatment within one week of diagnosis. This included 2 infants with congenital hypothyroidism, 2 with mild hyperphenylalanemia, 1 with galactosemia and 1 with PKU. If appropriate for support, families with newly diagnosed infants are offered contact with another family who has a similarly affected child.

In October 1998 Maine added Congenital Adrenal Hyperplasia (CAH) to its panel of tests. There have been no cases of CAH identified through screening. In September 1999, Maine added Biotinidase Deficiency to its panel of screening test. We were also able to add MCAD, the most common of the disorders identified via tandem mass spectrometry, with the availability of tandem mass spectrometry at the New England Newborn Screening Laboratory. An infant in Maine with another rare condition, PPA, was diagnosed and admitted to the NICU. Early identification of this child may have prevented the illness and disability associated with PPA.

Public & Community Health Nursing Referrals

These children and their families also receive referrals to Public and Community Health Nursing for home visits. The focus of these visits is to educate the family about the disorder, its treatment modalities, follow-up testing/monitoring, and general support and access to services.

Genetics Program Advisory Committee

The Genetics Program Advisory Committee is comprised of genetics professionals, consumers, nurses, BOH staff, including the MCH Medical Director and CSHN program manager. This group met in April to discuss provision of comprehensive genetic services in Maine. Recent changes in affiliations of some genetic providers, and MMC's plan to develop a genetics program, will change how services are delivered in Maine. The Committee discussed current services, identified unmet needs and proposed plans to meet those needs. Changes were made in grant agreements to assist in this process. The agencies will need to plan ways to improve access to services through outreach clinics, tele-medicine and education of providers and the public.

Newborn Screening Program Advisory Committee

There has been information in medical and lay journals, newspapers, web sites and TV about expanded newborn screening, so in April 2000 the Newborn Screening Program Advisory Committee met to review results of our current screening panel. The New England Newborn Screening Laboratory in Massachusetts screens specimens for 5 of the 6 New England states. Massachusetts began to offer a panel of screening tests which consists of 19 inborn errors of metabolism. Because these conditions are rare, and not much is known about the normal course of the disorder and the impact of early diagnosis and treatment, these are offered as a pilot study. The Advisory Committee recommended that Maine consider expanding the panel of screening tests done. A series of meetings are being planned to discuss each of the conditions and receive recommendations from the Advisory Committee regarding additional tests.

Federal Performance Measure #5

% of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

Populations Served: ■ Pregnant Women, Mothers & Infants ■ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #5

Provision of Immunizations

The National Immunization Survey (NIS) data available to the Maine Immunization Program (MIP) from the CDC's National Immunization Program, does not report on immunization rates as requested in FPM#5. (4-3-1-3-3, which includes Hepatitis B). However, Maine ranks second in the nation with a 88% immunization rate for the 4-3-1 (DPT-Polio-MMR) and 87% on the 4-3-1-3 (DPT, Polio, MMR and HIB). We are making an effort to increase the number of Maine children vaccinated for Varicella. We have a Vaccines for Children (VFC) program wherein the state purchases vaccines in bulk from the pharmaceutical companies and gives them to the providers. The vaccines are purchased with a combination of monies from CDC, VFC funds, State General Fund, and Health Maintenance Organizations (HMOs) doing business in Maine. Immunizations for Maine's children are provided through well child clinics, private providers, and some schools. Approximately 90% of all childhood vaccinations in Maine are administered by private providers (i.e. pediatricians, family practice, nurse practitioners) who may charge a $5.00 fee to administer the vaccine.

The MIP has worked for 2 years on the development of a web-based immunization registry. This registry, called Immpact, is a joint venture between the MIP and the New Hampshire Immunization Program. Immpact went on-line in late FY98. The program achieved partial rollout prior to the identification of hardware and software issues related to capacity. Further implementation is dependent upon completion of the hardware and software upgrades, which are expected to occur in the later part of FY00.

Federal Performance Measure #6

The birth rate (per 1,000) for teenagers aged 15 through 17 years.

State Performance Measure # 2

The % of unintended births in women less than 24 years of age.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

Populations Served: ■ Pregnant Women, Mothers & Infants ☐ Children ☐ CSHCN

Program & Activities Contributing to Success of FPM #6 and State Performance Measure #2

Teen Family Planning Services

Pregnancy Risk Assessment Monitoring Survey (PRAMS) data for 1998 shows that 55.5% of women ‹ 24 years of age reported their pregnancy was unintended. This is a decrease from 1997 when 62.4% of women ‹ 24 years of age reported unintended pregnancy. The number of women reporting unintended pregnancies in 1998 is similar to 1996, when 54.7% of women ‹ 24 years reported unintended pregnancies. The rate of unintended pregnancy is higher for women ‹ 20 years of age (72.9% in 1998). For women aged 24 and older, the unintended birth rate continues to show a slight decrease. In 1998, 25.3% of women aged 24 and older reported their pregnancies to be unintended compared to 25.4.7% in 1997 and 26.7% in 1996. These statistical changes may be due to small sample sizes resulting in large rate changes with minor actual number changes.

Prevention of teen and unintended pregnancy requires addressing risky behaviors in youth and providing teen family planning services for those teens who are sexually active. According to the 1997 Youth Risk Behavior Survey (YRBS) data, 36% of Maine's high school students were sexually active during the 3 months prior to the survey; 51% of students who had sexual intercourse during the previous 3 months reported using a condom at last intercourse; 30% reported using Oral Contraceptive Pills at last intercourse. Unfortunately, 1999 is not a weighted sample and will make comparisons to other years difficult. The YRBS data does show continued issues of tobacco use, substance abuse, and depression. Efforts are underway to attempt to coordinate school survey requests in order to assure greater participation in our next YRBS survey.

Maine's Birth Rate for Teenagers Aged 15-17
Five year Moving Averages
1987-1996

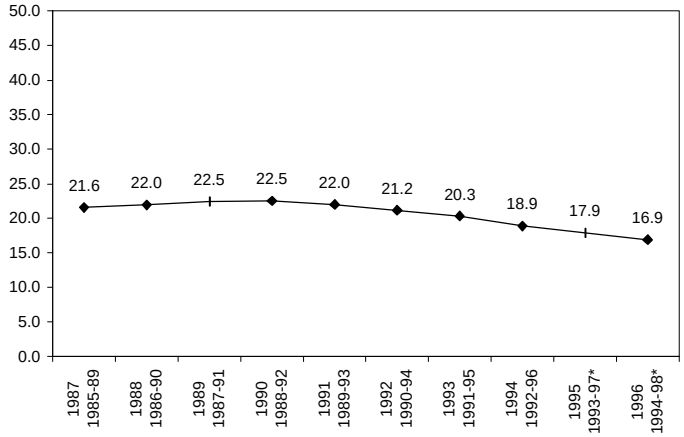


Table 5

Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics

Primary Pregnancy Prevention Projects

In addition to direct services, the Teen and Young Adult Health Program funds community and school programs to reduce teen risk behaviors and prevent teen pregnancies. The goal of these programs is to decrease the school drop-out rate, decrease pregnancy rates by 50%, and increase mother-daughter communication. One program also reported a decrease in substance abuse among participants. In 1998 two Primary Adolescent Pregnancy Prevention Projects served 109 teens in group and individual counseling sessions. Family Life educators, funded through the Family Planning Association contract, provided consultation to 155 schools (including in-depth technical assistance to 40 priority schools) and 2071 educators. One hundred middle school girls attended a conference to promote positive body image and self-esteem. Direct education and community outreach was provided to 6,386 students, 1534 parents and community members. Eighty people attended a family life education conference for teens and educators that was organized by the Family Life Education Program.

Teen Leadership Capacity & Health Knowledge

Teen pregnancy can also be reduced by increasing teen leadership capacity and health knowledge. The TTAHP funds the Maine Council on Adolescent Health, which advocates for healthy choices by Maine's youth and provides support to service providers across the state. The Maine Health Education Resource Collection and two personnel in the Department of Education are funded through the MCHBG and state funds. These resources help schools build a comprehensive health education curriculum and provide access to health education resources. During FY99 771 items from the Health Education Resource Collection were circulated throughout the state. TYAHP also funds and supports training for peer leader programs. This includes in-depth technical assistance to new programs in 8 schools and a state-wide conference attended by 334 youth.

Family Planning Association

For those teens who are sexually active, Title X Social Services Block Grant (SSBG), state general funds, and a limited amount of Title V funding supports 8 local family planning agencies through the Family Planning Association of Maine. These local agencies provide clinical family planning services through 32 statewide clinics. In FY99 they served 9,582 of Maine's total of 89,504 adolescents ages 15-19 years of age (approximately 10%). Overall these clinics served 29,793 clients of which 17,147 were women at or below 150% of federal poverty level.

Federal Performance Measure #7

% of third grade children who have received protective sealants on at least one molar tooth.

State Performance Measure # 4

The percentage of children with obvious need for dental care.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐ Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ■ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #7 and State Performance Measure #4

During the period covered by this report, the Oral Health Program continued to pursue its mission to improve the oral health of Maine people through three approaches: community prevention; planning and assessment; and community and professional education and training services.

Community prevention activities include promoting the use of community water fluoridation and supplemental fluorides; promoting the use of dental sealants by private and public dental care systems; and encouraging early screenings of high risk populations for early identification of disease and referral for oral disease intervention, as well as oral health promotion and education.

Planning and assessment services include the provision of consultation and technical assistance to government agencies, non-profit organizations and other groups to facilitate the delivery of quality oral health care services in all areas of Maine; and the conduction or facilitation of oral health assessments of Maine citizens to evaluate oral health status and treatment needs, for use in program planning and policy development.

Community and professional education and training services include assisting schools and communities in implementing oral health promotion activities and educational programs, through funding, consultation and technical assistance; developing oral health promotion and disease prevention educational materials and making them available to the public and other agencies; and providing updated oral health information to dental and other health professionals through appropriate channels.

During the past year, the Oral Health Program continued with many of its traditional activities. However, there were two staff changes during the year (out of four positions), leaving the one health educator/dental hygienist position vacant for 4 months and the one clerical support position vacant for six weeks. The legislative session was particularly busy for OHP staff, with several relevant proposals and more focus on oral health issues. In the last quarter OHP resumed activities to complete its Oral Health Needs Assessment, by implementing the 1999 Maine State Smile Survey.

A meeting of the Oral Health Needs Assessment Advisory Committee was held in early April. At this meeting, the Advisory Committee endorsed the Oral Health Program's plan to proceed with a statewide screening of kindergarten and 3rd grade students during the spring and fall of 1999. The Committee also agreed that existing secondary data, as reported in the May 1998 Interim Report, should be updated through the summer and fall. A training session for screeners participating in the screenings was held at the end of April. The training included a calibration for about 8 registered dental hygienists from around the state.

1999 Maine State Smile Survey

The Oral Health Program conducted this survey as part of a statewide needs assessment to help define what types of oral health problems exist for elementary school children in Maine, what types of services are currently available, and the extent of unmet needs or underutilized resources. Based on a national model, the survey focused on children in kindergarten and third grade. Schools were chosen to participate based on random samples stratified by region. The overall response rate was only 54%; the children screened represented only 7.3% of all enrolled students. Therefore, the results must be limited to describing children screened, not the state as a whole. Regardless, it is believed the participating schools were representative of the state and that the findings present a reasonable accurate picture of the oral health of Maine school-age children. It appears the majority of children have good oral health with poor oral heath and difficulty in accessing services associated with low socioeconomic status.

Dental Sealants

During the year ending June 30, 1999, ~1000 children received sealants at the four dental clinics funded through the Oral Health Program. The total number of sealants provided indicates an average of 3.7 sealants per child. The 1999 Maine State Smile Survey, which collected data on kindergarten and third grade students throughout the state, is expected to give us a more accurate and broadly based indicator of the statewide prevalence of sealants. Early and very preliminary analysis indicated that almost 40 percent of the 3rd-graders screened had at least one dental sealant, and that a higher percentage needed at least one additional sealant placed.

Technical assistance, including information and loans of portable equipment, continued to be provided to groups working to implement school- or community-based sealant programs. In addition, the OHP added a voluntary dental sealant component to its School Oral Health Program (SOHP), which supports school-based classroom education and fluoride mouthrinse programs through about 80 grants to about 250 elementary schools annually. OHP sponsored a training session in October 1998 to present information relevant to schools that had been funded to provide sealants to second grade students. A new Maine sealant manual was presented at the training to guide coordinators and dental hygienists in implementing the new programs. In the school year ending in June 1999, eight local SOHPs added the sealant component, offering free dental sealants to children with parental permission in 22 schools. There were 403 children seen and 1,317 sealants provided (about 3.3 sealants per child). This number was less than projected by half, and is attributable to delays in local program implementation, lower than anticipated permission rates, weather, and problems with portable equipment. However, both the local programs and OHP staff were satisfied with the results.

The OHP also applied in May 1999 to the federal Maternal & Child Health Bureau for additional funding through its Community and School Based Sealant Programs grant program. [The application was approved and funded in August 1999 for three years.]

Preventive Dental Program in Well Child Clinics

In conjunction with the DCFH's Public Health Nursing Program, and supported with Title V funds, OHP continued to offer a Preventive Dental Program in DHS-funded Well Child Clinics. This program provides parental education, toothbrushes, and supplemental fluoride when appropriate to children who attend these clinics; testing of well water for fluoride is also facilitated through the program. In FY99, approximately 170 fluoride prescriptions were provided to preschool age children at no charge through this program. All children involved in Well Child Clinics are eligible for the educational services. Over the past few years the number of supplemental fluoride prescriptions has consistently decreased, as has overall enrollment. OHP staff plan to evaluate the Preventive Dental Program within the context of the projected evaluation of the Well Child Clinic Program.

School Oral Health Program

The OHP coordinates the School Oral Health Program (SOHP), a voluntary classroom-based education program that in many communities includes a fluoride mouth rinse component. Small grants are provided to individual schools, school districts, and several community agencies acting on behalf of schools; for the 1998-99 school year, OHP made 83 grants to support the program in 253 schools. These programs provided education to approximately 51,000 children (more than 40% of children in those grades), of whom about 75% participated in the fluoride component of the program. Participation in the School Oral Health Program has been generally consistent over the past several years. Technical assistance is provided to the school representatives throughout the year; regional annual training meetings were held in the fall of 1998 and planned for September 1999. As noted elsewhere, a sealant component, added on a voluntary basis for the 1998-99 school year, is supported with MCH funds (state match). In that first year, eight local SOHPs added the sealant component, offering free dental sealants to children with parental permission in 22 schools. For the 1999-2000 school year, four more SOHPs applied for funding; this will mean sealant programs in 37 schools. The projected number of students to receive sealants is not available.

The OHP continues to use Title V funds to partially support community-agency sponsored dental health education programs in two of Maine's most rural and underserved counties (Aroostook and Washington). Both programs provide coordination, facilitation and support to the SOHP and serve as public oral health promotion resources in their areas.

In June of 1999, the OHP applied through the Maine Department of Education for three years of funding from the Centers for Disease Control to support the "Maine School Oral Health Initiative" as part of CDC's Oral Disease Prevention in School-aged Children Using School-based or School-linked Oral Health Programs announcement. This opportunity was available only to those states funded by CDC for school health infrastructure programs, designed to foster collaboration between state education and health departments. The Maine project's

goal will be to improve the oral health of at-risk school-aged children by evaluating and improving the existing SOHP, and to increase access for these children to oral health education, promotion and treatment services. (The application was approved but not funded; however, in May 2000 the OHP received unofficial notification from CDC that a two-year award would be effective in September.)

Maine's Dental Clinics

Maine currently has relatively few non-profit dental clinics. In the year covered by this report, there were eight freestanding facilities (one public, the others private) administered by three agencies. Four rural community health centers provide dental care, and a few facilitate access to dental services. These facilities are not geographically well distributed, and serve a comparatively small number of people. Community groups in several areas (e.g. Waterville, Ellsworth, Bucksport and Bath) have initiated efforts to develop non-profit dental health centers. The groups in Waterville and Bucksport in particular made substantial progress in this grant year toward achieving their goals of starting new dental centers. The OHP provides technical assistance to these and other groups on an ad hoc basis.

At the end of this grant year, with the end of the First Regular Session of the Maine Legislature (June 1999), a budget allocation of $1 million was made to support community-based oral health programs. This was written into the budget but will be funded with dollars from Maine's tobacco settlement money; the program and its funding are not effective until July 1, 2000. Of this $1 million, $250,000 is to support the development and expansion of community-based oral health programs; $650,000 is to be made available to programs providing oral health services using sliding fee scales to subsidize those fee scales; $50,000 is for case management, community education and oral health education; and $50,000 is for Medicaid targeted case management. All but the latter will be administered through the Oral Health Program.

Oral Health Program Grants

The OHP administers small grants totaling $64,000 to three agencies (two private non-profits and one municipal health department) to support four of the state's eight dental clinics, pursuant to legislative action about 10 years ago. Data for FY99 indicate that 4,066 children and adolescents received clinical dental services in a minimum of 6,787 visits to these clinics (one site's data are incomplete). At least 67.2% of the total number of patients (all ages) seen at these clinics were Medicaid eligible, and 24.5 were not. The insurance/payment status of the others is not known. The primary reason for about half the total number of visits was identified as diagnostic or preventive, and as restorative/surgical for about one-third. As noted elsewhere, nearly 1000 children received sealants at these clinics; the total number of sealants provided indicates an average of 3.7 sealants per child.

At the end of FY98 the OHP made four small grants (one of $2,700 and three $2,750) through a special Capacity Development Mini-grant Program. The purpose of these grants, made to community-based organizations working as coalitions to advance oral health promotion and disease prevention activities, was to provide support, seed money, or matching funds to facilitate the organization's ability to further develop, initiate or sustain a new program. Results indicate a substantial "return on investment." Two grantees used their awards to help fund needs

assessments. One, the "Oral Health Survey of Washington County Preschool Children," resulted in a report and local press coverage and is being used to educate participants in a projected Washington County Dental Health Task Force. The other, conducted by the Hancock County Dental Coalition, took longer to complete in both the data collection and analysis stages; outcomes were still pending at the end of this grant period. The Waldo County Dental Task Force funded a project developer who applied successfully for several major grants and set up a volunteer-centered free clinic program. The Kennebec Valley Dental Coalition supported community outreach and used their award as match for other grant applications.

Consultation and Technical Assistance Services

OHP staff continued to provide consultation and technical assistance to several groups around the state in their efforts to establish community-based oral health programs and services to improve the oral health status of and access to care by low-income and Medicaid-eligible children and their families. Staff continued to provide support to the Maine Dental Access Coalition (MDAC), convened in June 1997 in conjunction with the Maine Children's Alliance, a private non-profit children's advocacy organization. The MDAC is a broad-based group comprised of representatives from the OHP, the Maine Medicaid Program, the Maine Dental and Dental Hygienists' Association, health and social services organizations, consumer advocacy groups, and interested individuals. The group's mission is to promote the importance of preventive and restorative oral health services throughout Maine. To help sustain and expand the work of the MDAC, the OHP also applied in May 1999 to the federal Maternal & Child Health Bureau for support through its Oral Health Integrated Systems Development grant program. (The application was approved and funded in August 1999 for four years.)

Oral Health Promotional Materials

The OHP continues to disseminate information through programs such as WIC, Well Child Clinics, and home visits by public nurses, as well as via requests by community agencies, health professionals, schools, and others for oral health education materials. Families of infants served by MCH programs receive "easy-to-read" brochures on relevant oral health promotion topics and appropriate parenting practices for oral health and fluoride supplementation. A new brochure in this series, "Moms with Gum Problems" was developed during this year; its focus is on maintaining maternal oral health during pregnancy to help optimize outcomes. The OHP set an internal objective for the next year to develop a tracking system for our educational materials to better monitor what is being provided to whom and in what quantity.

Other activities

OHP staff made numerous presentations to educators, dental and other health care providers on topics related to improving children's oral health, health education and promotion, and early intervention; staff also participated in several workgroups and committees with similar goals. Among these activities (not described elsewhere) were:

- OHP coordinated a two-day training workshop on creating consumer-friendly health materials primarily for Division of Community & Family Health staff.
- Five regional School Oral Health Program (SOHP) Directors' Annual Meetings were held at the end of September. Topics covered included safe handling of fluorides in schools, dental screenings, Comprehensive School Health Education, and an update on the activities of the Partnership for a Tobacco Free Maine. The meetings also included time for local school dental program directors to share experiences and ideas, and for reviews and updates on grants administration procedures.
- The OHP manager participated in the state Rural Health Conference in November to moderate a session on "Oral Health in Rural Areas.
- The OHP manager coordinated a meeting in December for staff from the Bureaus of Health and Medical Services with regional representatives from HCFA and HRSA to follow up on the Oral Health Initiative sponsored by the two federal agencies and kicked off with a national conference the previous June.
- Teaching packets for use during National Children's Dental Health Month (February) were prepared by OHP staff for distribution to schools participating in the OHP-sponsored School Oral Health Program, and to others on request. The packet included a lesson plan for teachers on dental sealants. OHP also coordinated a statewide dental health poster contest with support from the Maine Dental Hygienists' Association.
- OHP staff presented a workshop for childcare providers, "Teaching Children about Dental Health," as part of a series of training opportunities sponsored by a local children's organization. The workshop explained the resources available through the Oral Health Program and provided some background and ideas for childcare providers on incorporating oral health education into their programs. Numerous requests for materials and information resulted from this workshop.
- The OHP health educator/dental hygienist participated in the annual statewide Health and Safety Child Care Conference sponsored in March 1999 by the Office of Child Care and Head Start and Maine's Department of Human Services. Approximately 150 childcare providers attended. The Oral Health Program had a resource table with information on early childhood oral health issues, and 26 child care workers attended a presentation to discuss their role in the identification and prevention of childhood oral health problems. She also made a presentation to a group of Early Head Start parents discussing the issue of Early Childhood Caries.
- The OHP health educator/dental hygienist attended a symposium on Early Childhood Caries sponsored by the Connecticut State Dental Association in April.
- OHP staff participated in several community/school health fairs and wellness days during the spring of 1999. One of these events was specifically designed to present faculty and staff with literature on the types of health information that can be available to students, and ideas on how to incorporate health issues into curricula.
- OHP staff attended the Maine Dental Association Annual Meeting in June. A display illustrating the work of the Oral Health Program and information explaining resources available to the dental community through the OHP were presented.

- The OHP health educator/dental hygienist presented a series of round table sessions at the 1999 Maine Schoolsite Health Promotion / Wellness Conference in June. Information on oral health resources and activities for schools was presented to participants representing schools statewide.

Federal Performance Measure #8

The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

State Performance Measure # 5

The motor vehicle death rate among children 15 to 21 years of age.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐ Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ■ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #8 and State Performance Measure # 5

Motor Vehicle Death Rate

In 1998, Maine reported a motor vehicle death rate of 2.2/100,000 to children 1-14 years of age. It should be noted that comparing rates from year to year may be misleading due to the small number of motor vehicle crash deaths in Maine. The National Center for Health Statistics has qualified their reports by noting rates are not considered reliable when based on fewer than 20 deaths. Maine's 5-year average death rate (1994-1998) for children ages 1-14 killed in motor vehicle crashes is 5.06/100,000. The motor vehicle crash death rate among children ages 15-21 years of age during 1998 was 31.3/100,000. This is an increase from a rate of 24.2/100,000 in 1997. Again, this may be statistically unreliable due to small numbers. The 5-year average death rate (1994-1998) for ages 15-24 years is 26.7/100,000.

Maine's Fatal Unintentional Injuries
Due to Motor Vehicle Crashes
Death Rate per 100,000 Among Youth Aged 15 Through 24 Years
Five Year Moving Averages 1987-1996

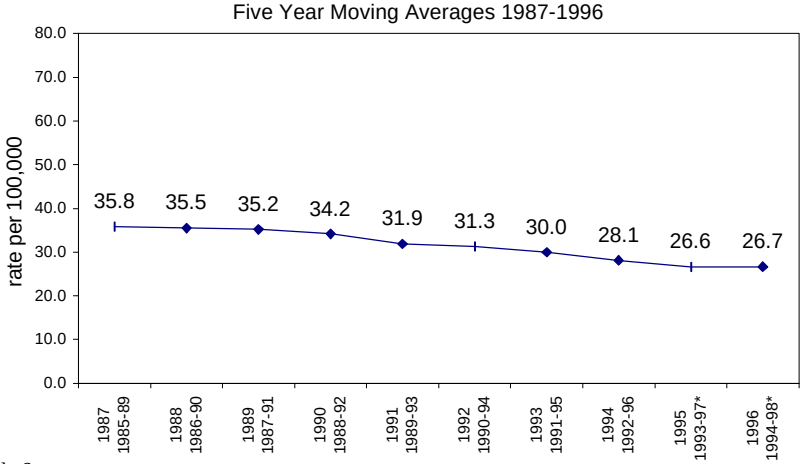


Table 6

Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics

*indicates preliminary data

Child Passenger Safety Promotional Materials/Media

- Child passenger, bicycle, and pedestrian safety educational information was provided to 25,000 individuals, and organizations throughout the State.
- In partnership with 58 Child Safety Seat Loan Programs, approximately 3500 pieces of information on child passenger safety issues were distributed statewide by the Maine Injury Prevention Program (MIPP)
- In partnership with the 20 Bucklebear Project sites, the MIPP distributed approximately 80,000 pieces of information on pedestrian, bicycle & child passenger safety to children and parents statewide.
- In partnership with the Maine Transportation Safety Coalition's (MTSC), Public Education & Information Work Group, a quarterly newsletter, a brochure entitled Traffic is Always in Season, and the MTSC Safety Notes newsletter were distributed statewide to schools, law enforcement departments, transportation agencies, coalitions, and other transportation safety advocates.
- Child passenger safety information, pedestrian safety information and bicycle safety information was frequently provided to the media.

Child Safety Seat Program

- Over 1500 Child Safety Seats were purchased and distributed to 60 Child Safety Seat Loaner Programs statewide.
- For Child Passenger Safety Week (2/99), Thanksgiving Holiday (11/99) and Buckle-Up America Week (5/99) MIPP assisted the MTSC's Seat Belt Committee with development of occupant protection planners and information to be distributed to law enforcement agencies and other high visibility community efforts.

Child Safety Seat Presentations

- The 20 Bucklebear Project sites provided approximately 70 presentations reaching 800 children and 85 parents on child passenger, bicycle and pedestrian safety issues.
- MIPP presented four (4) Annual Child Safety Seat Loan Program workshops to loan program coordinators in Augusta, Portland, Bangor, and Caribou. Loan Program coordinators received the revised Maine's Child Safety Seat Loan Program Manual which included the operational guide and the National Highway Traffic Safety Administration's Child Passenger Safety Technician Participant's Guide to CPS.
- MIPP staff participated in a child safety seat checkpoint at Walmart in Brunswick in partnership with the Town of Brunswick Police Department. This checkpoint completed the requirements for national CPS technician certification for five (5) of Maine's CPS technicians.
- MIPP staff presented a CPS training to the Central Maine Power Safety Team members in Augusta. The purpose of the training was to provide a general awareness of the problems and issues with child passenger safety today.
- MIPP staff presented an overview of child passenger safety at the Knol-Wal Inn Nursing Home, Rockland in partnership with the Maine Safety Council and Maine Network of Employers for Traffic Safety program. This presentation was part of an overall employee safety program.

- MIPP staff, in collaboration with other agencies, hosted Maine's First NHTSA's Child Passenger Safety Technician training in Portland. The 4 day training was attended by law enforcement, loan program coordinators, EMS and Fire personnel, Safe Kids coordinators, and other CPS advocates. Four of Maine's CPS technicians became certified instructors.
- MIPP staff presented the CPS presentation to the Abused Women's Advocacy Project in Lewiston, and Building Blocks Day Care in Augusta.
- MIPP staff presented an overview of the Safe Community concept of community organizing at the Lewiston-Auburn Councils of Government in Auburn.
- MIPP staff was interviewed by Channel 13 on Child Passenger Safety and kick-off of CPS week during February 1999.
- MIPP staff participated in the CPS Kick-Off Event at the Portland Pirates in Portland.
- MIPP staff presented a child passenger safety overview at the Portland Water District at an employee safety breakfast during CPS week (2/99).
- MIPP staff presented an overview of the Operation Kids and NHTSA's CPS Technician curriculum at the law enforcement District #2 Training in York at the annual Maine Chiefs of Police conference.

In addition to the above, MIPP staff made presentations and/or provided training to the following groups:

- Together with a representative from Region I, NHTSA, MIPP staff presented an overview of Safe Communities model of community organizing at a Town office meeting in Glenburn, ME.
- MIPP staff attended the second annual OUI (Operating Under the Influence) Awareness Kick-Off Event with staff from the office of the Secretary of State and Maine Turnpike Authority and Maine Transportation Safety Coalition (MTSC).
- In collaboration with MTSC, MIPP sponsored and assisted in the development/presentation of Maine's Third Annual Transportation Safety Conference in April 1999. (160 attendees & over 50 exhibitors). During the conference MIPP staff participated in child traffic safety breakout sessions.

Maine Transportation Safety Coalition

The Maine Transportation Safety Coalition continues to promote the advancement of child traffic safety initiatives. This non-profit coalition is a partnership of local and state agencies collaborating to promote safe transportation throughout the State of Maine. The MTSC Board consists of designated members representing several state agencies including the Department of Public Safety, Office of the Secretary of State, Department of Professional and Financial Regulation, Department of Transportation and the Department of Human Services. The activities of the coalition are accomplished through workgroups (WG) that include Seat Belt WG, Public Education & Information WG, Conference WG, and the Communications WG. The Seat Belt WG continues to collaborate and provide leadership to other professional associations in occupant protection initiatives. The MTSC, Board of Directors, received the Governor's Teamwork and Safety Award on Thursday, September 16, 1999 at the Annual

State Employees Recognition Day. The coalition was recognized for their multi-agency team approach to providing safer transportation in Maine.

Grant Applications

- MIPP staff assisted in the development of NHTSA's, Section 157 Grant Application to increase seat belt use in Maine. Official notification of the grant award has not been made in writing, however verbal approval of the award has been received.
- MIPP staff assisted in the development of the APHA/NHTSA grant application to increase seat belt use in Maine. The Maine Medical Association and the Maine Public Health Association received official notification of the award in the amount of $10,000. This award will be used to support the development & printing of an occupant protection brochure, resource guide, and child passenger safety workshops targeting the medical community.
- The MIPP assisted in the development of the National Sheriff Association/NHTSA grant application to increase seat belt use in Maine. The Maine Sheriff's Association received notification of the award in the amount of $20,000. This award will be used to support training in the Operation Kids and Child Passenger Safety Technician training for law enforcement personnel, and public awareness education activities.

Other MIPP Activities Related to Child & Adolescent Safety:

Fire Safety Cooperative Agreement with the CDC

MIPP staff continued to work with the Maine Fire Service and other public health and safety professionals to conduct the three-year CDC-funded fire/burn prevention and smoke alarm installation campaign. Over 1,300 at-risk households have received an in-home inspection to assess the prevalence and functionality of residential smoke alarms. Households found to have insufficient fire detection were provided with a means to receive free 10-year lithium-battery smoke alarm(s) for their homes. Fire safety educational materials were also provided to each study participant, including instructions for installation and maintenance of the alarms.

Over thirty-five fire departments were recruited and trained to administer project materials to the study participants. Other partners include Public and Community Health Nurses, Healthy Families Program, State Fire Marshals Office, Bureau of Elder & Adult Services, Native American communities, and the Maine Independent Living Services.

Fire Incident Surveillance

As in the previous year, funds received from the Cooperative Agreement were used to print the redesigned Maine Fire Incident Report, a collaborative effort among the Maine Fire Chiefs' Association, the State Fire Marshal's Office and Sunpro, Inc., a computer software company. The Report is an effective tool used to collect and analyze fire incident data in Maine, and is distributed to fire safety professionals throughout the state.

Presentations and Public Education

In October of 1998, staff from the MIPP presented and exhibited at the 10th Annual Pine Tree Burn Foundation Conference. An overview of both the MIPP and the CDC-funded fire/burn prevention program was provided to the 100+ attendees.

Fire safety educational material continues to be added to the loan library, including videos, lesson plans, booklets and brochures. The MIPP continues to partner with the Fire Service in the distribution of information concerning juvenile arson. A representative from the MIPP attends meetings and participates on the Maine Fire Safety for Children Task Force, a committee that deals with the problem of juvenile arson.

Media Efforts

Two weekly newspapers published articles related to the Cooperative Agreement with the CDC to promote residential fire safety. The coverage was very positive, with particular emphasis on the need for Maine residents to properly install and maintain smoke alarms on every level of their homes.

During the winter season (a time which typically sees an increase in fatal fires), MIPP staff arranged to have a public service announcement stressing the importance of residential smoke alarms aired on radio stations throughout the state.

Youth Violence Prevention

The Maine Injury Prevention Program (MIPP) sponsored community based youth violence prevention projects in Milo, Lisbon, and the greater Waterville area from 1996 through 1999. During FY 1999, the program funded the University of Maine, Peace Studies Institute, the University of Southern Maine, EXCEL Program, and the Office of the Attorney General Civil Rights Team Project. These programs are briefly described below. MIPP also sponsored quarterly meetings with a diverse group on individuals for the purpose of coordination of activities. MIPP also maintains and disseminates a statewide listing of prevention resources. In addition, MIPP organized the annual youth violence prevention conference in August.

The Peace Studies Program of the University of Maine

This offers education on the roots of violence and conflict, prevention methods teaching, and skill development opportunities through academic courses, lectures, conferences, and annual summer institutes at introductory, intermediate, high school levels. The program also offers a statewide newsletter, a lending library and a trainer referral service. Campus Mediation of the University of Maine, an organization to provide peer mediation to University students, is supported by training and program staff oversight. Also a statewide organization of conflict resolution (CR) educators was created during the fiscal year. This organization was formed to provide a forum for Maine conflict management educators to meet and exchange CR ideas, successes, and challenges.

EXCEL (Excellence in Citizen Education through the Law)

This is a coalition composed of the University of Maine School of Law, the USM College of Education, the Maine State Bar Association, and the Maine Bar Foundation. EXCEL is funded through a grant from MIPP, contributions from its coalition partners, and fees and contracts for its training services. EXCEL provides basic and

advanced training, technical assistance and evaluation consultation to schools to establish conflict management and peer mediation programs. Also, the Program sponsored summer institutes; mock trial events and conversations with law leaders for high school youth; and a lending library. In FY 1999, EXCEL staff worked with local schools in northern Maine to assist them in instituting and/or evaluating school and/or community conflict resolution programs. In cooperation with MIPP and the EXCEL Program at USM, the program co-sponsored an association of peer mediators whose youth delegates met regularly and participated in semi-annual conferences.

Civil Rights Teams in Maine Middle Schools and High Schools

The Office of the Attorney General and the Maine Departments of Education, Mental Health and Mental Retardation, and the MIPP co-sponsor civil rights teams in Maine. The civil rights teams consist of three students per grade and one or two faculty advisors who work to provide in-school education and awareness on issues of bias and prejudice. Additionally, the teams create mechanisms by which students can provide information about harassment directly to team members, who in turn pass the information on to appropriate school or law enforcement authorities. There were more than 100 teams supported in schools all around the state during FY 1999. MIPP staff met quarterly with youth violence prevention grantees and other organizations doing related work in order to improve coordination of efforts. In August 1998 the MIPP sponsored an annual youth violence prevention conference entitled the "Whole School Approach to Youth Violence Prevention". The conference was primarily attended by participants from Maine schools.

Firearm Safety

MIPP saw its relationship with law enforcement at the state, county and local levels grow during FY99. Program presentations were conducted by MIPP staff and provided to departments during their staff meetings. Also see description of firearm safety education under youth suicide prevention section.

Other Core Health Indicator Activities

- MIPP staff maintained an active role in the Maine Association of Health Physical Education, Recreation & Dance (MAHPERD). The MIPP health educator is a member of the Executive Board, ensuring that child injury prevention will remain a priority focus of MAHPERD activities.
- MIPP participated in various local and national media events highlighting injury prevention. Events included: U.S. PIRG Press Conference on toy safety; interviews with WGME 13 on Shaken Baby Syndrome and Maine Public Radio.
- The MIPP health educator conducted Employer health & child safety informational sessions at several large employers. The presentation topics, geared toward parents and care givers, included safety tips for home, water, bikes and toys; how to respond to choking, strangling, fire; shaken baby syndrome; youth violence; and juvenile arson.
- Once again during Poison Prevention Week, packets including information about inhalants, plants, the uses of ipecac, etc. were distributed to over 100 agencies statewide.

- Consumer Product Safety Information was routinely disseminated to PHN, Health Centers, Teen & Young Adult Health Programs and others. Mass mailings were done six times during the year. Each contained approximately 24 informational bulletins or recall notices.
- MIPP staff provided health and safety exhibits/presentations at the annual MAPHERD and Wellness Conferences for school-based organizations. An estimated 300-500 individuals attended each session. Staff from MIPP participates on the Boards of each organization.
- MIPP continued its partnership with Central Maine Power Company. Several safety sessions were conducted for their employees around the state.
- In recognition of Violence Prevention and Fire Prevention month in October, MIPP distributed 5000 reflector Halloween bags to law enforcement, fire service and educators. The bags contained violence prevention and fire safety information geared to elementary level students.
- The MIPP contracted with the Maine Coalition for Safe Kids (MCSK) for 6 months during FY 99. MCSK provided injury prevention materials and training statewide and distributed over 100,000 pieces of educational materials and provided training on a variety of child injury prevention topics at schools, auto dealerships, health fairs, and to individuals.
- The MIPP continued funding three Safe Community Coalitions in Farmington, Portland and Augusta. These coalitions provide training and educational information on various injury prevention topics including child passenger safety, bike helmets, home safety, etc.
- In addition, the MIPP funded two additional Safe Community Coalitions in Lubec and Norway, Maine. These coalitions were funded for a four-year period beginning in July 1999. Injury prevention topics to be addressed by the new coalitions include child passenger safety, bike helmets, pedestrian safety, recreation safety, home safety, etc.
- The Maine Poison Center continued to receive a grant from MIPP during FY 99. The Poison Center provides statewide toxicology consultation services for professionals and the public, which provides information and treatment guidance to callers with exposure to a toxic substance. The Center serves approximately 26,000 Maine citizens annually. MIPP is involved in discussions with other New England states regarding establishment of a regional Poison Center.

Federal Performance Measure #9

% of mothers who breastfeed their infants at hospital discharge..

State Performance Measure # 3

Percent of women breastfeeding infants at six months of age.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

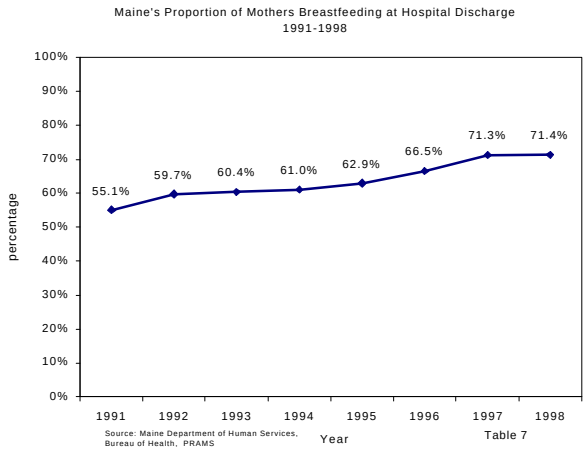
Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

Populations Served: ■ Pregnant Women, Mothers & Infants ☐ Children ☐ CSHCN

Program & Activities Contributing to Success of FPM #9 and State Performance Measure #3

Breastfeeding Programs

Many of the programs within the Division of Community and Family Health (DCFH) have established the goal of increasing breastfeeding rates among Maine mothers and infants. These programs include: Public and Community Health Nursing, WIC, MCH Nutrition, Healthy Families, and the Teen and Young Adult Health Program (TYAH). Maine's most accurate data source for information on breastfeeding rates at hospital discharge comes from the newborn screening filter paper forms**.** Data reported for CY98 indicate 61.2% of newborns were exclusively breastfed, 32.4% were bottle fed, 3.2% received a combination of breast and bottle feeding, and 3.2% were unknown. This represents a 4.9% increase since CY92 and a 1.4% increase since CY95 in infants being exclusively breast fed at the time of discharge. The quality of the breastfeeding data may be questionable because the category of exclusive breastfeeding is not clearly defined on the filter paper form. Therefore, the health care providers completing the form may not be consistently using the same definition.



The maternal and infant benefits of breastfeeding continue through the first year of life. For this reason it was decided that a state performance measure (#3 The Percent of women breastfeeding infants at six months of age) would assist in monitoring this important health indicator. Maine is one of the states with a Pregnancy Risk

Assessment Monitoring System (PRAMS) project; however, it only captures data on infants through 13 weeks of age so therefore can not be used to report on this measure.

Duration of breastfeeding data is currently very limited and the departure of our data analyst with no rehire makes compilation of data very difficult. There is no source of data through six months of age which can be generalized to the state as a whole. At present WIC is the only source of data with information regarding breastfeeding status on infants 13 weeks and older. These numbers do not represent exclusively breastfed infants.

Unfortunately, this data is limited by the lack of non-standardized definitions of breastfeeding and by the methodology used to aggregate the data. PRAMS data is helpful in terms of providing insight into why women stop breastfeeding, but the survey is done at 12 weeks post-partum which negates the possibility of obtaining data for the six-month duration. Community Health Nursing also collects and reports breastfeeding data, but it is limited to the first few weeks or months. Currently, we lack the electronic/computer resources to completely analyze this data.

The WIC Breastfeeding Coordinator chairs the Maine Breastfeeding Coalition (formerly titled the Maine Breastfeeding Task Force). The Maine Breastfeeding Task Force formed in 1990 under the leadership of the state in response to the discrepancy between the growing body of research evidence documenting breastfeeding as the optimal form of infant nutrition and Maine's low breastfeeding rates. Five regional arms of the task force were developed based upon the five public health nursing regions of the state. Members were volunteer health professionals, including but not limited to lactation consultants, nurses, dieticians, health educators and social workers.

Over the years, activities of the task force have targeted both health professionals and families. Information has included breastfeeding awareness exhibits at health and agricultural fairs, assuring media coverage (i.e. press releases, news coverage, radio/TV public service announcements) during World Breastfeeding Week, development of a Breastfeeding Success Guide and a state Resource Guide. Membership has recently broadened to include community members in fields other than health care. To reflect this broader membership, the group's official name was changed from Maine Breastfeeding Task Force to the Maine Breast Feeding Coalition. This Coalition has revised strategies to target the broader community and to engage in a community needs assessment regarding breastfeeding support and the development and implementation of an action plan. The timeline for completion of the assessment/action plan project is one year. The WCPHS Program collaborate each year with MCH Nutrition and WIC to produce the annual MCH breastfeeding conference. In 1999 this conference was attended by 127 health care professionals.

During FY99 the PHN and WIC programs discussed ways to increase breastfeeding education and support. These programs share the goal of increasing the initial and long-term breastfeeding rates in Maine. As a start, a plan was developed to increasing the number of lactation counselors available to childbearing women involved in the PHN and/or WIC programs. During FY99 four WIC staff successfully completed training and became certified lactation counselors. In FY00 additional PHN and WIC staff will receive this training and achieve certification.

Federal Performance Measure #10

% of newborns who have been screened for hearing impairment before hospital discharge.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

Populations Served: ■ Pregnant Women, Mothers & Infants ☐ Children ☐ CSHCN

Program & Activities Contributing to Success of FPM #10

Newborn Hearing Screening

Routine newborn hearing screening in Maine has been adopted on an individual hospital basis. Interest of birth hospitals/providers in providing this important screening prior to discharge is increasing. In CY98 nine of the thirty four birth hospitals in Maine performed some form of hearing screening, providing 13% of newborns with hearing screening. Six of these facilities screened all newborns and three screened infants "at risk" for hearing impairment, Twelve other hospitals are planning to implement newborn hearing screening. The program manager for the Genetics Program has participated in discussions with audiologists regarding implementation of a statewide initiative for newborn screening. A legislative bill has been introduced (1999 Legislative session) that, if passed, will mandate universal infant hearing screening and formally establishing the Newborn Hearing Program.
This bill will be discussed during the next legislative session.

In April 2000 a workshop is planned for three locations in Maine: Portland, Bangor and Presque Isle. Brochures announcing the workshop will be mailed to nurses from birth hospitals, community agencies and public health nurses, audiologists and early intervention staff. The purpose of the workshop is to provide a forum to discuss newborn hearing screening, and to share information from hospitals that are successfully screening newborns. Representatives from DCFH are meeting with advocates and audiologists to discuss issues related to implementation of universal newborn hearing screening.

Federal Performance Measure #11

% of Children with Special Health Care Needs in the State CSHCN program with a source of insurance for primary and specialty care.

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ■ Capacity ☐ Risk Factor ☐ Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ☐ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #11

During FY99 the CSHCN Program provided services to 1,324 children through clinics and the Program, however the CSHCN Program is only able to report on the 923 served through the Program. Of those children, 765 (83%) had a source of insurance for primary and/or specialty care. This is a 26% increase from FY98 and may be an indication that families have accessed the Medicaid Program for services and/or the economy has allowed people who were previously uninsured to be insured. Sources of insurance for children included the following:

Type of Insurance	Number of Children
Medicaid Only	313
Medicaid and Third Party Liability	151
Third Party Liability	301
No Insurance	158
Total	**923**

The clinic form used to collect data on children who access the clinics proved to have an error on the question regarding insurance. Parents answered that they had health insurance (private insurance) and then continued to respond yes to the Medicaid question. It became apparent in reviewing the data that the results were skewed towards families having both insurance and Medicaid. During FY01 this form will be corrected and re-administered.

Of the 464 children who receive Medicaid, 206 receive Medicaid through the Federally administered SSI program, 34 have the Deeming Waiver (Katie Beckett), 7 have Cub Care (Title XXI), 88 receive Prime Care (Medicaid Managed Care) and the remaining 129 are eligible for Medicaid through a variety of different categories. Medicaid covers both primary and specialty care.

The CSHCN Program continues to assist families with third party liability with co-pays and/or deductibles even though their insurance pays for primary and specialty care.

The remaining 158 children with no insurance are covered for their specialty care (but not primary care) by the CSHCN Program. These families are sent applications for Cub Care and we continue to encourage families to enroll in CubCare.

Federal Performance Measure #12

% of children without health insurance.

State Performance Measure #1

Access to comprehensive health care services to serve adolescents.

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ■ Capacity ☐ Risk Factor ☐ Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ■ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #12 and State Performance Measure #1

School-Based Health Centers

Access to comprehensive health care services for women and children, particularly adolescents, has been identified as a state priority. By the close of FY99 there were 14 school-based health centers (SBHC) in operation in Maine with five additional centers in development. Seven of these SBHCs received state funding, two of which were new centers this year. One of the new centers had construction delays and they did not offer services in FY99. Approximately 1,327 students were served through the six funded centers. The DCFH sponsored meetings of all SBHC representatives to develop uniform evaluation and tracking processes and to provide education and networking for center staff.

Public Health Nursing Well-Child Clinics

The MCH program, through PHN and Community Health agencies (the latter are grantees of the WCHPS) conduct well child clinics in various locations throughout the state. The PHN clinics serve children ages birth through 6 years of age. The Community Health agencies serve children birth through 21 years of age. During FY99 PHN conducted 48 clinics where a total of 676 children were served. Of these, 675 were ages birth to 5 years. The remaining 1 child was over 5 years of age. The CHNs served an additional 2,257 children in their well child clinics and school immunization clinics.

An evaluation of state Well-Child Clinics began in FY99 and continued into FY00 in an effort to determine the usefulness and cost-effectiveness of this modality for providing preventive health care services. Progress in establishing “medical homes” for all Maine children, and increases in insurance availability suggest that identification with primary care providers and a possible voucher program for those continued uninsured may be a better approach than Well-Child Clinics. This evaluation effort has been conducted by interns under the guidance of the MCH Medical Director and the Director of Family Health.

Percent of Children Without Health Insurance

In 1997 Maine's Children's Health Insurance Program (CHIP) Task Force contracted with the University of Southern Maine's Muskie School of Public Service, and subsequently Mathematica Policy, Inc., to determine the extent of uninsured children in Maine. They completed a survey of 2,449 households and found that 10% of children in Maine were uninsured.

In FY99 and early FY00 the Bureau of Medical Services (Maine's Medicaid agency) replicated the 1997 survey. The 1999 survey used the same survey methodology, instrument, and weighting methodology. The sampling frame was smaller secondary to cost constraints. A sample size of 8,141 households was selected with the expectation of finding 100 households with uninsured children and obtaining another 300 interviews with low-income households with privately insured children.

To date, only preliminary data is available from the replication survey. Early in Spring 2000 a preliminary report was released based on completion of 66% of the low-income households with privately insured children interviews. The preliminary data indicates less than 10% of Maine's low-income children are without health insurance and that the Maine CHIP program is having a positive impact on increasing the number of low-income children in our state with creditable health insurance coverage. As reported on page 8, 82,415 children are insured through Medicaid.

Federal Performance Measure #13

Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program..

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ☐ Capacity ☐ Risk Factor ■ Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ■ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #13

IMMPACT

Responsibility for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) outreach activities was transferred to the Bureau of Health in January 1998. This program has been added to the Maine Immunization Program (MIP) which utilizes Maine's new immunization registry system called "Immpact". As all children in Maine will be a part of this registry, and the registry monitors insurance status, Immpact will facilitate the informing, assistance and monitoring functions of EPSDT. The expected automation of select EPSDT functions has been delayed by needed adjustments to the hardware and software within Immpact. It is anticipated that these features will be available sometime in FY01.

CHIP

During FY98, the Commission on Child Health Insurance organized Maine's response to the federal Child Health Insurance Program (CHIP). Maine's plan was approved in August 1998, with enrollment beginning late August/early September 1998.

Maine's CHIP plan combines Medicaid expansion with a state-developed program entitled "Cub Care". Maine Medicaid had, for many years, covered newborns to one year of age at 185% of Federal Poverty Level (FPL). As of October 01,1999 the maximum FPL for Medicaid expansion and CubCare was increased to 200% FPL, thus more pregnant women, infants and children are eligible for insurance via the Bureau of Medical Services. This combination of programs essentially provides coverage to children birth through 18 years of age up to 200% of FPL. The children have six months of continuous eligibility. Families whose income is greater than the maximum FPL at the end of an eligibility period may purchase coverage for up to an additional 18 months.

Cub Care and Medicaid expansion offer the same benefits provided under Medicaid and use the same service delivery system.

Despite the recent availability of expanded Medicaid and Cub Care, many children within the state remain uninsured. This lack of coverage is associated with decreased acquisition of preventive health services and poorer overall health status. In light of this Maine's CHIP program goals are:

- Increase in the number of children with insurance coverage as measured by a decrease in the uninsured rate, an increase in Medicaid participation, and the number of children enrolled in Cub care.

- Conduct an effective outreach program as measured by the number of mailings and home visits, the number of spots aired in TV and radio markets, and approval of all outreach material by advocates
- Ensure consistent source of care as measured by the number of enrolled children in plans, the number of enrolled children who have a primary care provider, and a decrease in the emergency department use rate
- Improve health outcomes as measured by an increased early childhood immunization rate, an increased adolescent immunization rate, and an increased EPSDT follow-up rate.

Outreach Activities

Community Health and Public Health Nursing continue to participate in outreach efforts by making follow-up home visits if the EPSDT outreach staff is unable to locate families and/or enroll their children. In addition, efforts continue to increase enrollment through simplified applications, mail in opportunities, and public education to increase child care providers', primary care providers', and other community service providers' awareness of the program. Enrollment through schools has been a very successful outreach activity.

Several consumer advocate agencies collaborated on a successful application to the Robert Wood Johnson Foundation for CHIP outreach funding. Their outreach activities for consumers and education for providers began in FY99 and will continue through FY00 and FY01. These sessions have proven to be a useful tool for informing the public about the growth of the CHIP program, particularly as it relates to changes in eligibility.

Federal Performance Measure #14

The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ☐ Capacity ☐ Risk Factor ■Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ☐ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #14

The CSHCN Program continues to recognize parents as an essential component in developing a family-focused, community-based, culturally-diverse program and has supported families in the following areas:

Southern Maine PKU-Metabolism Clinic

As part of the Program's new initiative to increase family participation, a parent of a child with PKU has been added to the team of experts. As the parent representative on the team this individual brings the perspective of a family adjusting to the discovery of a newly diagnosed condition, experience with a PKU diet, dealing with school issues, and knowledge of how to access the wealth of information that is available to PKU families.

PKU Camping Weekend

This interactive weekend is designed for children with PKU and their families. A host of speakers are invited to instruct families on diets, drawing blood samples, discuss emerging issues and support each other in a family friendly environment.

Family Advisory Council

During FY99, the Family Advisory Council (FAC) was quite active in both CSHCN policy development and program activities. The FAC meets monthly in Augusta and the CSHCN supports members by providing a stipend, transportation, lodging and child care reimbursement. The Program's Family Care coordinator assist the FAC Co-chairs in developing agendas, providing workshops and training, and the Program's clerical person adds support by typing minutes and sending agenda items to participants. During FY99 the FAC developed by-laws that included a vision and mission statement and goals. The composition of the FAC is limited to 18 members, 3/4 members must be parents, family members or legal representatives of children who are or who have received services from the CSHCN Program. The remaining 1/4 may consist of community members who have demonstrated leadership in the services to children with special health needs. Family members represent a culturally diverse group of individuals from all 16 counties in Maine. Other members represent mental health services, public health nursing and the Maine Parent Federation.

CSHCN Strategic Planning

As part of the MCHB's five year needs assessment the Program initiated a strategic planning process in November 99. Families from the Program have been actively involved in developing a CSHCN Program vision and mission statements; areas to be addressed in the next five years, and goals and strategies for implementing change. It has been a pleasure to have parents involved in the creation of new programs that will serve children more effectively in the future.

Family to Family Support Network

The CSHCN and the Family Voices councils worked collaboratively during FY99 to develop a Family to Family Support Network. This statewide program will be piloted in FY00. The aim of the program is to carefully match a supporting parent with a newly referred family in a one-to one-relationship. The supporting parent will provide practical ideas on how to cope with the new situation, an understanding of the available resources, and a shared common experience.

Workshops

The CSHCN Program financially assisted several parents to enable them to attend training and workshops. These workshops include Parent's as Advocates, an annual PKU conference and Utica College's Celebrating Children Child Life Conference where two parents, a public health nurse and the Family Care Coordinator presented *"The Stages of Development of a Family with a Child with Special Health Needs: From Pre-diagnosis through Advocacy."* The CSHCN Program would like to thank MCHB again for sponsoring a parent of a child with special health needs to attend AMCHP. Ms. Pulsifer found the conference very interesting and was able to network with other family member from across the nation.

Federal Performance Measure #15

% of very low birth weight live births.

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐ Process ☐ Outcome

Populations Served: ■ Pregnant Women, Mothers & Infants ☐ Children ☐ CSHCN

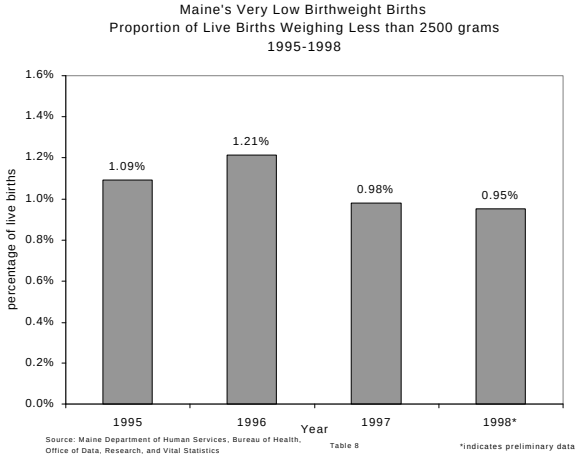
Program & Activities Contributing to Success of FPM #15

Please reference the Perinatal Outreach Education grant managed by Women's and Children's Preventive Health Services Program (Page # 70) the Public Health Nursing activities (Page # 74) and Prenatal Care (Page # 72) and the Family Planning Services Grant managed by the TYAHP (Page # 40) for additional activities that strive to decrease the percentage of very low birth weight infants. Public Health Nursing and Community Health Nursing also both offer Tobacco Cessation counseling during home visits.

Stages of behavior change are also used to measure success related to alcohol and other substance use.

At this time none of the cessation data is grouped into pre or post natal populations.

Maine had a slight decrease in the number of very low birth weight live births from 134 in 1997 to 130 in 1998. This decrease is probably statistically insignificant due to the small number of very low birth weight infants born in Maine. Comparing rates from year to year could be misleading because a small increase or decrease in the actual number of very low birth weight infants has the potential to result in large rate changes. Without further research we are unable to identify any specific reason for this slight decline, although we hypothesize that it may be a reflection of regionalizing high risk perinatal care with maternal and infant transport systems; providing access to early prenatal care; and promoting a low adolescent pregnancy rate.



Federal Performance Measure #16

The rate (per 100,000) of suicide death among youths aged 15-19.

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐ Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ■ Children ■ CSHCN

Program & Activities Contributing to Success of FPM #16

Youth Suicide Prevention

Suicide is the second leading cause of death among Maine adolescents & young adults (vehicle crashes are the most common cause of death in this age group). The Maine youth suicide rate has been above the national average suicide rate for fourteen out of nineteen years (1979 - 1997). In CY 98 there were 9 suicide deaths among Maine youths ages 15-19 years of age (10.1/100,000) which is a slight decline from CY97 when there were 14 suicide deaths among Maine youths aged 15-19 years (16.1/100,000). The 5 year average (1993-97)is 10.2/100,000. The tragedy of a youth suicide has a devastating impact on an entire community and these statistics poignantly represent the need for continued development and refinement of interventions and identification strategies. (*Note*: Due to the small annual number of youth suicides in Maine, staff typically use suicide rate data in five-year periods to compare trends over time. The National Center for Health Statistics has qualified their reports noting that rates are not considered reliable when based on fewer than 20 deaths.)

Maine's Suicide Death Rate
Youths Aged 15-19 (rate per 100,000)
Five Year Moving Averages, 1987-1996

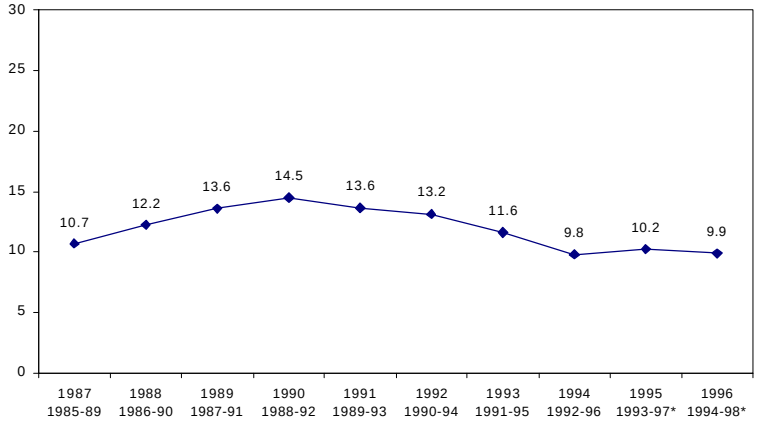


Table 9

Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics *indicates preliminary data

Maine Youth Suicide Prevention Program (MYSPP)

Following recommendations produced by the Governor appointed Task Force in 1995, a comprehensive plan to prevent suicide among Maine youth ages ten to twenty four was developed and funded as a collaborative initiative of Governor Angus S. King, Jr. and the Children's Cabinet. The Children's Cabinet represents

Commissioners and senior staff from the Departments of Human Services; Mental Health, Mental Retardation, and Substance Abuse Services; Education; Corrections; and Public Safety.

MYSPP implementation began during the summer of 1998 with Cheryl DiCara, Director of the Maine Injury Prevention Program, as coordinator. The program consists of multiple strategies designed to build a supportive infrastructure to aid Maine families and children in need of prevention, intervention, and crisis services to prevent youth suicide.

The Maine plan was organized according to CDC recommendations in four levels:

- *Universal*, or public awareness activities;
- *Selective*, or activities directed at identifying and assisting groups of youths who may be at high risk;
- *Indicated*, or specific strategies to connect with and assist individuals known to be at highest risk; and
- *Data and Evaluation* strategies to measure the impact of prevention programming and to monitor Maine and national youth suicide trends.

During this fiscal year MYSPP activities included:

Statewide Crisis Hotline

A statewide crisis hotline was established. The hotline connects the caller to the nearest crisis service provider in the area from which they are calling.

Statewide Information Resource Center

Statewide resource information on suicide prevention was incorporated into the Office of Substance Abuse Information Resource Center in the Department of Mental Health, Mental Retardation, and Substance Abuse Services. A MYSPP Web site was also established. Informational materials including six regional resource directories "Yellow Pages for Teens", and posters were developed and disseminated to teens. The MIPP Health Educator collaborated with law enforcement officials to develop the "law and you" portion of the Teen Yellow Pages booklet. Some police departments distribute these booklets directly to teens as needed.

Materials developed for adults include numerous books, an information booklet, and training resource materials on the topic of youth suicide prevention.

School Based Awareness Education

In spring 1999, the Department of Education made mini-grants to integrate youth suicide prevention within the comprehensive school health education curriculum available to 14 schools.

Community Awareness Education

Awareness sessions to increase public understanding about suicide prevention ranging from 90 minutes to 2 hours were delivered to audiences statewide. Schools, service agencies, community groups, and professional meetings and conferences provided opportunities for disseminating the message to individuals. Radio and television programs also helped to disseminate the program message. Youth suicide prevention was included in all MIPP presentations conducted by the MIPP Public Health Educator, and suicide prevention educational materials were included in all MIPP training packets.

In January of 1999, law enforcement officials at the local, county, and state levels along with members of the MYSPP met at the Maine Criminal Justice Academy to discuss training needs in the area of suicide prevention for both new recruits and veteran police officers.

Media Guidelines

Guidelines to encourage accurate and effective reporting practices were developed and disseminated to school administrators and media reporters.

Gatekeeper Training

An intensive training program, developed in part with a federal EMSC grant, began in fiscal year 1999. The Maine Gatekeeper Training Program was delivered to 84 EMS workers throughout the state and individuals in direct contact with youths in school and community settings. The training was delivered in a regional one-day program to individuals from 152 schools and 76 agencies. In addition 4 schools hosted an on-site training day for their staff members. "Gatekeepers" were trained in the basic skills to prevent suicide including recognition of young people who may be at risk, appropriate responses and how to refer them for help.

Lethal Means Education

Lethal means education has been incorporated into all MIPP training sessions and into all gatekeeper-training sessions. MIPP developed a one page fact sheet and, with the assistance of law enforcement, an information sheet about removing firearms from the home. These are distributed whenever possible.

Skill Building Support Groups for Youth

An in-depth (4 ½ day) training the "Reconnecting Youth Program" was offered in August 1998 and June 1999 to train adult facilitators to conduct skill-building groups for teens. This training strives to enhance youth resiliency and reduce the risk of suicide or other self-destructive behaviors by providing young people with support groups where they can learn and practice life skills. A total of 20 participants attended the Maine sponsored sessions. Five schools were implementing RY by the end of the fiscal year. Three state employees also attended the summer institutes.

The MIPP Data Specialist coordinated the activities of the MYSPP Data and Evaluation Team . Team members include representatives from the university system, private health data organizations, Maine Kids Count, and several state data agencies. The group reviewed data on suicide risk factors, provided data for the statewide suicide prevention Web site, and assisted in the training on E codes.

The MIPP monitors suicide incidence and attempts through available data systems. One focus of the MIPP data and evaluation specialist has been to design a system to collect youth suicide attempt data to enable us to determine the magnitude and demographic characteristics of this self-destructive behavior. Several youth suicide attempt data sources have been explored. One critical source of youth suicide attempt data is the Emergency Medical Services (EMS)/ambulance service run report. As of January 1, 1998, EMS/ambulance services used a check-off box on the run reports that indicates the incidence of suicide attempts and suicidal tendencies. MIPP data staff has been tracking EMS runs for patients with suicidal tendencies and attempts.

Inpatient hospital discharge data is another important source of suicide attempt information that is improving with increased E coding. During April of 1999, E code technical training was provided in Portland and Bangor to increase hospital participation in E coding and to improve coder skills.

The percentage of Maine hospitals E coding their inpatient records increased from 74.6 percent in 1997 to 87.2 percent in 1998. Only 4 of the 38 hospitals were below a 70 percent coding rate in 1998.

These existing data sources do not provide a complete picture of suicide attempts in Maine. During FY98 the MYSPP began working with key stakeholders on the conceptual design and development of an adolescent suicide attempt data collection system. The development of this system will greatly enhance our ability to collect and analyze data.

As part of the initial planning process, short and long-term outcomes were developed to aid in the evaluation of program strategies. Analysis of state, regional, and national data was compiled initially and is monitored on an ongoing basis.

Shaken Baby Education Program

Requests for Shaken Baby Syndrome (SBS) prevention education continue to increase. MIPP staff attended a four-day SBS Prevention Conference in Salt Lake City in September of 1998. As a result of the conference workshops, a formal 90-minute SBS prevention presentation was developed for use in Maine. This includes pre/post knowledge surveys for participants. To date we have conducted presentations for daycare providers, PHN, child abuse and neglect councils and other child safety advocates. Educational materials, including posters and SBS prevention postcards geared toward males, have also been incorporated into the overall SBS packet distributed to hospitals, daycare cites and any agency working with parents and caregivers.

In April of 1999, MIPP sponsored its first statewide Shaken Baby Syndrome Prevention Conference. Individuals representing law enforcement, the medical and legal community, child and family services, injury prevention and parents were featured speakers. Over 70 people attended the daylong event.

The MIPP also monitored legislative documents that related to the crime of murder of children. “Jake’s Law” LD474 was introduced by a parent whose four-month-old son was the victim of SBS. This law entitled “An Act Related to the Crime of Murder and the Murder of Children” was passed in the January 2000 legislative session. Specifically this law requires that the murder of a child less than six years of age be a special consideration in sentencing.

Federal Performance Measure #17

% of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

Populations Served: ■ Pregnant Women, Mothers & Infants ☐ Children ☐ CSHCN

Program & Activities Contributing to Success of FPM #17

The Women and Children's Preventive Health Services

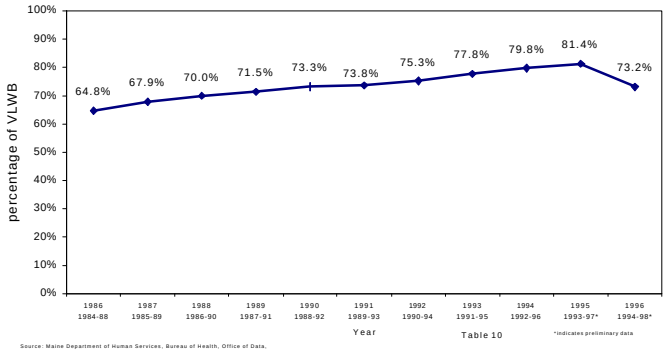
Efforts to improve maternal and infant health status in Maine are complicated by our geography and population distribution. Multiple routine services for women are available locally prior to the occurrence of a pregnancy and continue through the postpartum period. Routine pediatric services are also locally available through the first year for infants. However, our high-risk services are located in our three largest cities with Level III Facilities located in Portland and Bangor and a Level II facility in Lewiston.

The Women and Children's Preventive Health Services

The Women and Children's Preventive Health Services program manages a grant with Maine Medical Center for the provision of perinatal outreach activities which include provider and consumer education regarding issues pertinent to pregnancy outcomes. During FY99, the perinatal outreach coordinator and other professionals provided 88 educational opportunities. 990 providers attended these sessions. Topics included: basic and advanced fetal monitoring; obstetrical emergencies; violence against women; and breastfeeding. A small portion of this grant funds the 24-hour statewide availability of perinatology and neonatology consults for providers.

Great care is taken to transport high-risk pregnant mothers to the appropriate facility prior to delivery. However, in the event this is not possible, or an infant is born with unexpected complications, both Level III facilities facilitate transport via provision of a specially trained and equipped neonatal transport team utilizing both air and ground transport.

Maine's Proportion of Very Low Weight Births < 1500 grams
Delivered at Level III Facilities
Five year Moving Averages
1984-1998



Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics

Table 10

*indicates preliminary data

Indicators of well being for childbearing women and infants in Maine suggest that in general, this population is doing well, as reflected in the perinatal related national performance measures. During CY98, the

percent of very low birth weight live births, (national performance measure #15) was relatively stable at 0.9%; the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, (national performance measure #17) CY98 was 83.1%, nearly a 1% decrease from CY97; and the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester, (national performance measure #18) CY98 was 88.5% a 0.1% increase from CY97.

The planned formation of a Maternal and Infant Mortality Review (MIMR) will increase our understanding of factors affecting these measures. Preliminary meetings of Bureau of Health stakeholders have been held in an effort to respond to data, trends, and sentinel events, and to ensure statewide involvement. A MIMR planning meeting was held September 22, 1999 to determine objectives, scope and goals of a review. Representatives from professional organizations and state agencies attended: AAP, ACOG, AFP, AWHONN, March of Dimes, Perinatal Outreach Program, Medical Examiner's Office, Office of Data Research and vital Statistics, Public Health Nursing, Genetics Program, Women & Children's Preventive Health Services Program and Epidemiology. This meeting affirmed interest in and a need for ongoing maternal and infant mortality monitoring

The Family Health Program continues to examine and work through issues related to development of an ongoing MIMR committee. Maine's "small town atmosphere" created by our geography and areas of low population density, make it critical that we design appropriate formats for review that maintain confidentiality. Conversations with the Attorney General's Office, representatives of American College of Obstetrics and Gynecology, and American College of Family Practice and the Maine Association of Family Practitioners are ongoing. National models including the Fetal and Infant Mortality Review process (FIMR) are being studied and considered. It is our plan to integrate CFR, MIMR, and CDSITF as appropriate to ensure evaluation of all child and youth deaths within the state.

Federal Performance Measure #18

% of infants born to pregnant women receiving prenatal care beginning in the first trimester..

Pyramid Level: △ Direct △ Enabling △ Population-based ▲ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

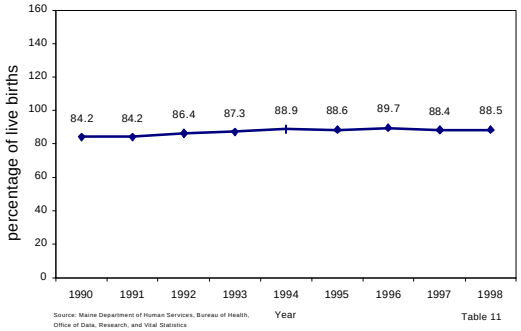
Populations Served: ■ Pregnant Women, Mothers & Infants ☐ Children ☐ CSHCN

Program & Activities Contributing to Success of FPM #18

Prenatal care

In CY98 Maine recorded 13,685 live births. 12,136 of these infants were born to mothers who received prenatal care in the first trimester. This 88.5% of infants born to women who received early prenatal care represents a 0.1% increase from CY97 value of 88.4%. In recognition of the importance of early prenatal care, continuity of care, and access to quality services, home visit programs to insure optimal habits and to improve parturition have been strengthened. PHN, CHN, Healthy Families, and programs through TYAH focus on early identification of pregnant women and youth and their access to early and continuous care.

Maine's Proportion of Infants Born to Women Who Received Prenatal Care Beginning in the First Trimester
1990-1998



Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics

Table 11

Maine's Public Health Nurses

Maine's Public Health Nurses (Registered Nurses who are employed directly by the state) provide a variety of primary, secondary, and tertiary prevention interventions and activities. Fifty-two field nurses are regionally assigned to provide PHN services throughout the state. More than 50 % of their activities focus on the MCH population.

Public Health Nursing provided 46,205 home visits in FY99; 4,400 of these visits were for prenatal/high risk pregnancies; 5,638 were for high risk newborns/high risk infants; 2,083 were to individuals with chronic conditions; 211 were for children enrolled in the CSHCN program; 299 were for visits related to lead poisoned children; 49 were visits related to the 15 families who had experienced a sudden infant death (SIDS) and 3,007 were visits related to newly arrived refugees. It is not possible to report specifically on the number of home visits for non-high risk prenatal, postpartum and newborn visits, because the information system used to collect PHN data pools all data into one generic category titled "Preventive Health Services". This category also includes visits to other children or adults who do not fall into any other specific diagnosis/ program category. The total number of visits in this category was 43,796 for FY99.

Due to both the geography of the state, and the limited PHN staff, there is a need for additional assistance in the provision of MCH services. The Women and Children's Preventive Health Services Program (WCPHS) funds five (5) Community Health Nursing agencies to provide home health nursing services to mothers and children in specified regional areas. During FY97, this program was renewed through the RFP process. The process resulted in 5 of the previously funded agencies developing a collaborative plan to provide services within the southern third of the state. In addition, a grant was awarded to the Visiting Nurse Association of Aroostook County for the provision of MCH services in Caribou, and for monitoring pregnant and parenting adolescents in the surrounding area. These community health agencies made prenatal visits to 288 women; postpartum visits to 1770 women; visits to 2905 infants and children, and 147 children with special health care needs.

These Community Health Nursing Agencies have collaborated to develop performance indicators to measure outcomes they have identified and developed for their services. These are in addition to the state and federal indicators, albeit some of them do overlap. The following are examples of the CHN indicators measured in stages of success:

- 90% of all prenatal clients admitted into the MCH Program will be established with a primary care provider within one month of enrollment.
- 50% of all prenatal clients who use tobacco will reduce usage by delivery.
- 80% of all prenatal clients who admit to alcohol consumption will report reduced usage by delivery.
- 100% of all prenatal women will be able to state to the RN the benefits of breastfeeding by delivery.
- 80% of all prenatal clients experiencing family violence will recognize and verbalize that they are in an unsafe environment.
- 90% of all children will be up to date with immunizations in accordance with ACIP guidelines by the time of discharge.

In addition to the pregnant women, mothers, and infants receiving home visits through PHN and CHN, the state-funded "Healthy Families" program also provides home visits for this population. These Healthy Family sites began enrolling families in the last quarter of FY97.They saw 513 families in FFY99. Healthy Families has a strong child development and parent/child interaction focus and a minor health component while the PHNs have the reverse concentration. Efforts are underway to develop a truly collaborative model for home visits that avoids duplication, is strength-based, and driven by the needs of the family. Presently there are fourteen Healthy Family Sites providing services across the state. Six of the fourteen sites receive a portion of their funding from the Department of Human Services. Most started enrolling families in the last quarter of FY97 with programs expanding to capacity in FY98.

Adolescent Pregnancy/Parenting Projects

The Teen and Young Adult Health program funds thirteen (13) Adolescent Pregnancy/Parenting (APP) projects. The APP projects provide a variety of services to promote health, safety, and self-sufficiency including continuing education for the teen, prenatal care and referrals, childbirth preparation, infant/child development and

safety classes, parenting skills, and family planning referrals. One important goal of these projects is to assist pregnant teens to access early prenatal care thereby reducing the incidence of low/very low birth weight babies. Each project has an extensive referral network and follow-up services to assist teens to access the health, education and social services they need. In 1998 these projects provided case management services to 748 pregnant and parenting teens. In 1997, 7.9% of babies born to mothers younger than 20 years of age were low birth weight babies. By comparison, 3.8% of babies born to mothers served by the APP had low birth weights.

Comprehensive Genetic Services

The Genetics Program provided funds to three comprehensive genetic service agencies: 1) Foundation for Blood Research (FBR), 2)Eastern Maine Medical Center (EMMC) Genetics Program and 3)Maine Hemophilia Treatment Center (MHTC). FBR and EMMC provide clinical genetic services, while the MHTC provides comprehensive care services to a defined population group. The total number of individuals who received services for FY99 is 1835. This total number has increased from FY98 =1781 and FY97 = 818.

The Genetics Program manager serves on the Maine Folic Acid Council along with several other MCH program representatives who are also on the council (i.e. WCPHS and PHN). A educational campaign about the importance of folic acid for women was conducted in collaboration with the Maine Chapter of the March of Dimes. This year our target audience included other MCH agencies, medical providers and school nurses.

Fifty four educational offerings on a variety of topics related to genetics were provided for grantee agencies (FBR, EMMC, and MHTC) with 1311 attendees. Participants included parents, physicians, nurses, educators and others.

Pregnant women with a concern about their current pregnancy are given a high priority for referral, regardless of their genetic history. An estimated 90% of prenatal patients concerned about their current pregnancy were seen for comprehensive genetic services by grantee agencies within 14 days of referral. After consideration and review of available data, it has been decided to continue the use of this indicator to monitor agencies as they make changes in how they provide services.

Public Health Nursing, Community Health Nurses, and Healthy Families

The staff providing services through Public Health Nursing, Community Health Nurses, and Healthy Families provide enabling services to pregnant women, mothers, and infants by identifying community services that may meet an individual's or family's needs. These enabling services range from assisting with the completion of application forms necessary for services provided by other agencies, accompanying them to interviews, and providing transportation when necessary to keep scheduled appointments

State Performance Measure #8

Knowledge of the percent of overweight children and adolescents.

Pyramid Level: △ Direct △ Enabling ▲ Population-based △ Infrastructure

Type of Measure: ☐ Capacity ■ Risk Factor ☐Process ☐ Outcome

Populations Served: ☐ Pregnant Women, Mothers & Infants ■ Children ☐ CSHCN

Program & Activities Contributing to Success of SPM #8

1997 Maine Youth Risk Behavior Survey

Results given here represent 1997 data from the Maine Youth Risk Behavior Survey (YRBS) because lack. of school participation prohibited weighted sample collection in 1999. The 1997 YRBS indicates 29% of Maine's middle school students and 30% of our high school students described themselves as overweight. Nationally, 27% of high school students thought they were overweight. Almost half (49%) of Maine middle school students reported trying to lose weight. Nearly two thirds (63%) of these students were girls, and 33% were boys. Their weight loss methods included exercise, taking diet pills and laxatives, and vomiting. 46% of high school students were trying to lose weight; 66% were girls and 28% were boys. Nationally, 40% of students state they are trying to lose weight.

Maine students' participation in PE classes declined from 88% of students in seventh grade to only 14% in twelfth grade. The Maine Department of Education requires only one credit of physical education for awarding of a high school diploma. This minimal requirement, and the broad range of activities that satisfy the requirement, may influence the sharp decline in physical activity between grades 9 and 12. National data shows that 74% of ninth graders and 78% of 12 graders exercise for 20 minutes or more in a typical PE class.

The MCH Nutrition Program and the University of Maine designed a study to assess the nutritional and physical activity status of 9th grade students. The research was conducted during the 1998-1999 school year in eight schools. A total of 1,069 9^{th} grade students participated in the study. Students responded to a Nutrition and Activity Survey which consisted of questions pertaining to demographics, present physical activity patterns, perceptions of physical activity, perceptions of their weight, and types of food eaten and how often. The percent of body fat was determined for 41% of the respondents. Data analysis has yet to be completed.

The MCH Nutrition Program participated in the MCH data subcommittee to evaluate data for the MCH strategic planning process. The Nutrition Program was involved with the Division's nutrition and physical activity workgroup which was organized to develop a state nutrition and physical activity plan, share nutrition/physical activity information about related Division activities, and serve as a resource for other Division programs. The goal of the State Nutrition and Physical Activity Plan is to improve the health and well being of Maine citizens by outlining key issues, goals, objectives, strategies and policy recommendations to guide nutrition and physical activity programs. The plan will be developed by June 30, 2000.

2.5 Progress on Federal Outcome Measures

Outcome Measure #1: *The infant mortality rate per 1,000 live births.*
Outcome Measure #2: *The ratio of black infant mortality rate to white infant mortality rate.*
Outcome Measure #3: *The neonatal mortality rate per 1,000 live births.*
Outcome Measure #4: *The postneonatal mortality rate per 1,000 live births.*
Outcome measure #5: *The perinatal mortality rate per 1,000 live births.*
Outcome Measure #6: *The child death rates per 100,000 children aged 1-14 years.*

Population: Pregnant women, mothers, and infants.

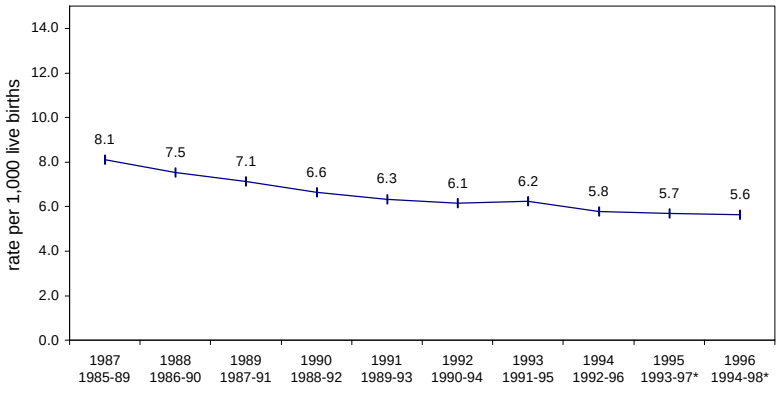
Maine's Infant Mortality rates

Maine has addressed several factors that contribute to infant mortality. Proven beneficial interventions include: regionalizing high-risk perinatal care with maternal and infant transport systems; providing access to early prenatal care; and promoting a low adolescent pregnancy rate. All these initiatives have contributed to maintaining our low infant mortality rate. Birth defects are known to correlate with both preterm labor and infant mortality. 24% of infant deaths in Maine are reported to be associated with birth defects. A new initiative to establish a Maine Birth Defects Surveillance Program will provide us with the opportunity to analyze data related to the occurrence of birth defects in Maine children. It will also allow us to plan for birth defect prevention efforts and program services. In February 1999 Maine established a cooperative agreement with the Center for Disease Control and Prevention to assist in the development and implementation of the Maine Birth Defects Program. Planning and development are progressing and case reports are expected to begin by the end of CY2000.

The 1998 *infant mortality rate* for Maine is 6.2 per 1,000 live births. A more accurate reflection of our infant mortality rate is the 1994-1998 five year moving average (midpoint year 1996) which is 5.6/1000.

The *perinatal mortality rate* was 8.1 per 1000 live births. The 1994-1998 five year moving average (midpoint year 1996) is 7.9/1000. The perinatal outreach program administered by the WCPHS and the newborn screening program both have activities and interventions aimed at positively affecting these rates.

Maine's Infant Mortality Rate
Rate per 1,000 Live Births
Five-Year Moving Averages 1984-1998



Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics

*indicates preliminary data

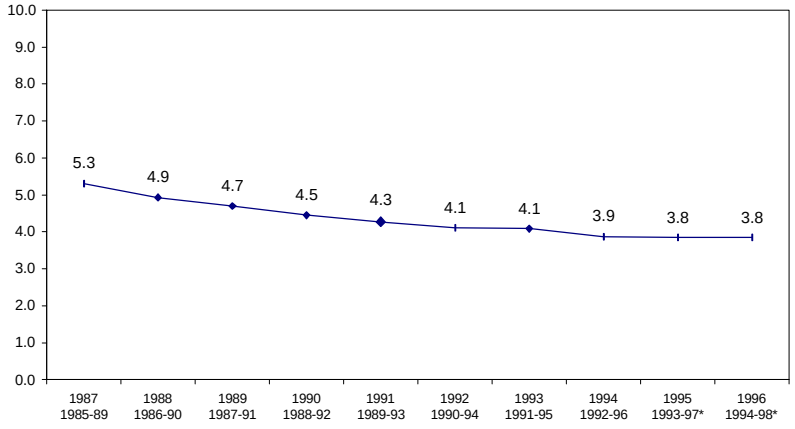
Table 12

The Perinatal Outreach Program's goal is to make cutting edge perinatal practice guidelines available statewide to providers including: physicians, nurses, nurse practitioners, nurse and direct entry midwives, nutritionists, and respiratory therapists on an "upon request" basis. Anyone who provides perinatal care is eligible to

attend and/or request educational programs. Program staff includes 1 full-time nurse educator who travels throughout the state, and 4 perinatologists and 7 neonatologists who collectively provide 24-hour availability of telephone consultation. The nurse educator also maintains a comprehensive resource lending library, chairs the Program Services Committee of the Maine Chapter March of Dimes, and is often called for expert chart review and quality improvement issues. In FY99 the Perinatal Outreach Program provided 88 educational opportunities that served 990 providers.

The *neonatal mortality rate* was 4.2 per 1000 live births. The 1994-1998 moving average is 3.8/1000. Further decreases are achieved through multiple programs including SIDS education, Public Health Nursing, WCPHS, MIPP, etc. Formation of the Maine Maternal and Infant Mortality Review (MIMR) and its proposed activities should help identify specific areas of concern allowing for further decrease via targeted interventions.

Maine's Neonatal Mortality Rate
Rate per 1,000 Live Births
5 Year Moving Averages1990-1998



*indicates preliminary data

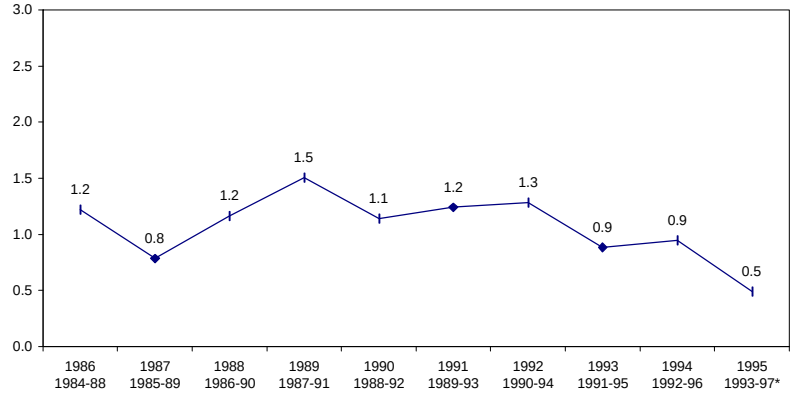
Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics

Table 13

Black Infant Mortality Rate:

The population of Maine is relatively homogeneous with persons of European descent representing 98% of the population. Minority populations include, in decreasing number, Asian and Pacific Islander, American Indian, and Blacks. The population distribution for Maine differs from that of states with more urban settings, and this must be considered when reviewing data. However, despite Maine's relative homogeneousness, increases in minority population –particularly through continued immigration– necessitate continued and improved surveillance and response to minorities' health status. The last five year moving average we have data for Black infant mortality rates is 1993-1997 (midpoint year 1995). The Black rate was 2.7 with a 0.5 ratio. During this same time frame the disparity between White and "Other" (Asian, American Indian, Pacific Islander excluding Black, White and Unknown) was 8.1 with a 1.5 ratio. If we consider the disparity between White and All Other Races (excludes White and Unknown) the 1994-1997 moving average is 6.9 with a 1.3 ratio.

Maine's Ratio of Black Infant Mortality to White Infant Mortality
Five Year Moving Averages 1990-1997



s preliminary data

urce: Maine Department of Human Services, Bureau of Health, Office of Data, Research, and Vital Statistics

Table 14

SIDS Program

Since 1973, Public Health Nursing has coordinated Maine's Sudden Infant Death Syndrome (SIDS) Program, acting as a liaison between the Chief Medical Examiners office and Public and Community Health Nurses. The Office of the Chief Medical Examiner reported 5 infants died suddenly and unexpectedly in 1999; confirmation from Vital Statistics is pending. This represents a significant decrease from the 15 SIDS deaths reported in 1998.

Program Manager Activities

The Program Manager continues to work collaboratively with the Maine SIDS Foundation (parent group). Referrals are made to the Maine SIDS Foundation for peer (parent) contact to newly bereaved parents.

In March 1999, the Family Health Program held a Risk Reduction and Research on SIDS Conference. This conference was attended by more than 60 physicians, nurses and family members. This conference addressed SIDS risk factors, risk reduction techniques/methods, and updates on SIDS etiology and epidemiology.

Also in 1999 a core group of SIDS Resource Nurses comprised of six Public Health Nurses was formed. This group reviewed policy, practice and resource materials regarding SIDS. In addition they received inservice training about SIDS from Dr. Greenwald, the Chief Medical Examiner for Maine.

The incidence of Shaken Baby Syndrome is monitored through news accounts and correspondence with police and the medical community. A formal method of tracking is not in place within the MIPP. Telephone conversations and correspondence from families, educators, the media and others involved with or using the Shaken Baby Syndrome materials have given us positive feedback about the usefulness of the materials.

In April 1999 a workshop was held to raise community awareness regarding Shaken Baby Syndrome. Presenters included representatives from law enforcement, the medical and legal communities, Child Protective Services, the Bureau of Health, and affected families. This conference was attended by law enforcement officials, child care providers, Public Health Nurses, medical professionals, and other interested parties. Plans are to hold this conference every other year with a repeat scheduled for April 2001.

Also in April 1999 as part of Child Abuse Prevention Month, information about SBS was mailed statewide to legal and health professionals. Our SBS specialist attended the National Conference on Shaken Baby Syndrome held in Salt Lake City, UT and will present on her prelease SBS counseling program for prisoners at next year's conference.

The SBS specialist also assisted with the passage of LD474 "An Act Relating to the Crime of Murder and the Murder of Children." As mentioned previously, this act promotes mandatory sentencing for the murder of children less than six years of age.

Maternal/Infant Advisory Committee & Maternal/Infant Review Committee (MIMR)

We continue to work toward formation of a MIMR, but have experienced difficulty with implementation due to changes in key staff positions. We plan to commence efforts and increase focus on neonatal and maternal issues in the next quarter.

Maine's Multi-disciplinary Child Death and Serious Injury Task Force (MCD & SITF)

The MCH Medical Director and the PHN Supervisor continue to serve on Maine's MCD & SITF. The panel provides multi-disciplinary, comprehensive case review of child fatalities and serious injuries to children. Cases reviewed include those of individuals previously reported to DHS as well as selected previously unknown cases that identify possible problems or issues regarding the safety of children in the State. All study cases are reviewed secondary to suspicion/concern of (but not proven) abuse and neglect. The focus in on services and

processes to identify and protect children at risk for abuse and neglect. The panel's findings and recommendations are shared with the Department of Human Services Commissioner and provided to the legislature and public for review. The purpose of such reviews is to identify the causes of child fatalities and serious injuries, and to promote prevention. Reviews are also utilized to make system changes that could prevent future child deaths under similar circumstances.

The Maine Child Fatality Review (CFR)

This committee has been formed in response to a need to review and monitor all child deaths within the state. Through a Memorandum of Understanding, and with assistance from the Office of Research, Development & Vital Statistics and the Maine Attorney General's Office, the Division of Community and Family Health, CIPCP, and the Office of the Medical Examiner are developing protocols and procedures for sharing data, monitoring trends and identifying interventions. Medical examiner data and death certificates, augmented with information from State Highway Safety, hospital information, and SIDS program data are reviewed. Additional efforts, including case and possibly hospital reviews, are being considered as next steps.

III REQUIREMENTS FOR APPLICATION

3.1. Needs Assessment of the Maternal and Child Health Population

3.1.1 Description of Needs Assessment Process and Design

We recognized that to effectively explore, analyze and address the health needs of our MCH population it would be necessary to design a multi-dimensional needs assessment with on-going evaluation of both process and outcomes. We also knew it was important for the various components of our assessment to provide accurate information from a variety of sources to avoid collecting data that simply justified existing programs and reinforced historical programmatic approaches. Our goal was to design a plan that would serve as a continual, valid evaluation process through which current and emerging needs of the MCH Population are identified, reviewed, evaluated and synthesized into our evolving programs and initiatives.

To accomplish this goal we opted to incorporate a variety of tools into our needs assessment design. This included a statewide strategic planning process that included stakeholders, an in-depth review and analysis of data directly relating to or impacting the MCH population, and a comprehensive needs assessment. The University of Southern Maine's (USM) Muskie School of Public Service also conducted extensive research and data analysis using interdepartmental data sources from the Bureau of Health's Family Health (FH) Programs, state, local, and federal agencies, non-profit groups and providers. (See Table 15)

Needs Assessment Methods:

1. Strategic Planning

The first step in our multi-part process was our strategic planning initiative. We enlisted the University of Southern Maine's's Muskie School Institute for Public Sector Innovation to facilitate a strategic planning process and to coordinate the comprehensive needs assessment. Staff from Muskie co-facilitated the strategic planning

sessions and public forums with the Director of Family Health Programs and the Family Health Medical Director. Important dialogue and feedback occurred that was essential for developing our plan.

The strategic planning process included key Family Health (FH) staff and stakeholders because we knew input from a cross-section of stakeholders was critical to the success of the process, and subsequently our comprehensive needs assessment. Over 1,000 members of the FH population were invited to participate in the forums. We identified key stakeholders as those individuals served by the Title V programs and organizations working with the FH population. This included school superintendents, the YWCA, Librarians, staff from Park and Recreation departments and special education teachers, just to name a few. To ensure the best chance of obtaining diverse perspectives, we intentionally included organizations with whom we contract for services and those we've never done business with. Over 200 individuals accepted our invitation and participated in some manner.

This statewide strategic planning process served as the primary venue through which the health needs of the Family Health population were identified, discussed, and prioritized. The Strategic Planning Process started in January 1999 with a "Planning to Plan" meeting of Division staff. This was followed by convening Workgroups to analyze Data, Organizational Capacity, Mandates, and Stakeholders. These Workgroups included representatives of both staff and key stakeholders. Concurrently we held Public forums with FH stakeholders. The forums were distributed statewide in six geographical locations.[i] An initial forum was held at each site to elicit feedback and identify needs and concerns. A subsequent follow-up meeting at each site allowed stakeholders to review and verify any needs or concerns identified in the first round of forums.

We also held two Retreats for the core group of Division staff to check on progress and direction during the planning process. A draft plan has been written and is currently undergoing internal review by Division staff and leadership. A third round of public forums to allow the members of the FH population a final opportunity to comment on the identified FH health needs, the priority of these needs, and the direction of the strategic plan will be scheduled for early Fall 2000. We want to ensure that the Family Health strategic plan addresses and encompasses the concerns and needs of the entire FH population.

2. Data Review and Analysis

Multiple data sources were analyzed to compile information pertinent to the need for services in each of the MCH pyramid levels (direct health care, enabling, population-based, and infrastructure). (See Table 15)

Due to our small numerators, we find following trends over time to be the most accurate method of analyzing our data. Vital statistics data is reported by ODRVS by calendar year and we conducted analysis for calendar years 1994-1998. Data obtained from Kids Count, ChildStats, and FedStats provided information necessary to evaluate Maine's comparative position to national data and U.S. averages.[ii]

Table 15

Data Source	Type of Data
BCFS Office of Child Care and HeadStart	Information and data regarding out-of-home care and services.
Behavior Risk factor Surveillance system (BRFSS)	Data regarding access to healthcare, mammograms and cervical pap smears as well as nutrition and physical activity
Center for Disease Control	National Health Statistics
Child Death and Serious Injury Task Force and Child Fatality Review Board.	Vital statistics concerning fatal and non-fatal unintentional injuries.
Childhood Indicators Policy Project (CIPP)	State and local data
Childhood Lead Poisoning Prevention Program	Maine state lab statistics
Coordinated School Health Program	Dept. Ed stats, and YRBS data
Family Planning, Newborn Screening, and the Maine Immunization Program	Data in their areas of concentration.
Kids Count; ChildStats; FedStats; State of Maine Web Page	State and National statistics
Maine Health Corporation**,** the Maine Health Information Center	Independent data source for discharge data, Emergency Dept. data, inpatient data sets and medical data (e.g. diagnosis)
Maine Injury Prevention Program and ODRVS	Vital statistics concerning fatal and non-fatal unintentional injuries
Maine Nutrition Network	Data and information about statewide nutrition and physical activity
Maine State Department of Mental Health, Mental Retardation, and Substance Abuse Services	State statistics
Maine's Bureau of Medical Services (BMS)	Data regarding both the availability of primary care and numbers of recipients of Medicaid and CHIP.
Maine's Department of Education	Data from their *Youth Risk Behavior Survey*. Data from the *YRBS* provided information on adolescent tobacco use, suicide, sexual activity, education, STI, Alcohol, families, depression, and mental health.
National Center for Children in Poverty at the Joseph L. Mailman School of Public Health of Columbia University	Data regarding family poverty
Oral Health Program Family	Needs assessment data regarding oral health
State of Maine Department of Corrections	State crime statistics
State of Maine Department of Labor	Statistics regarding employment and wages
State of Maine Planning Office	Childhood and family poverty data
The Children with Special Health Needs' Family Advisory Council	Contributed to this assessment by elucidating the current and emerging needs of CSHN stakeholders
The DHHS Health Care Financing Administration	Medicaid statistics and data. DHHS data was also used to review and compare state and national Medicaid information
The National Governors Association's Center for Best Practices	State and national data for Medicaid coverage levels.
The Partnership for Tobacco Free Maine	Information on preventive initiatives and current smoking rates.

Data Source	Type of Data
The U.S. Census Bureau	Information related to low income uninsured children.
U.S. Census data and the State's ODRVS	Basic demographic data
U.S. Department of Commerce's Bureau of Economic Analysis and the State of Maine Planning Office.	Data related to economic factors impacting the FH population
U.S. Department of Labor's Bureau of Labor Statistics, Institute for Research on Poverty at the University of Wisconsin-Madison	Statistics on employment and wages
Women's and Children's Preventive Health Services (WCPHS)	Data concerning risk and low birth weights

3. Evaluation and Planning Cycle

Maine's cycle for program planning and evaluation is intrinsically linked to its performance contracting and performance budgeting initiatives. In 1991 the Maine State Government convened a Special Commission on Governmental Restructuring which proposed a system of performance budgeting based on measurable performance objectives. In 1995 the Legislature created Maine's Commission on Performance Budgeting to study the issue and make recommendations to the Legislature and Governor. Many of their recommendations resulted in laws establishing a performance budgeting system, requirements for each state agency to conduct a strategic planning effort, and establishment of a system of performance-based contractual agreements with private/nonprofit vendors for the purchase of social services.

In 1996 the Department of Human Services took the lead and, with input from consumers, service providers, legislators and agency staff, developed a contracting system that would serve all the state's contracting agencies. The final product was a system based on four elements: performance goals and indicators that were common to all contracts (and non-negotiable) and contract strategies and measures that were to be negotiated on an individual basis between the state agencies and their vendors. Statewide training for both staff and vendors was coordinated by the University of Southern Maine which also offers on-going consultation and training on the topics of performance-based contracting, logic models and strategic planning.

In 1997 the goals and indicators had been identified for all service areas and the negotiation of measures and strategies within contracts began. It quickly became apparent that common measures were critical to evaluation and the process of developing common measures within similar services is underway. Through our State Systems Development Initiative (SSDI) project the Family Health Programs began work with the University of Southern Maine's Muskie School of Public Service, Institute for Public Sector Innovation, to develop training workshops on performance measurement, how GIPRA fits with Maine's performance-based contracting, and to develop consistent measures across common contract areas. To date, Family Health program managers and other staff managing contracts have participated in the workshops. The next step is to repeat the workshops with the Family Health staff and their grantees.

This entire process has been diagramed as our Evaluation and Planning Cycle. See Exhibit 1

Strengths and Weaknesses of Current Methods

Strengths

1. Maine's Public-Private Partnership

Maine's total population of only 1.2 million citizens, many of whom descend from families who have resided here for generations, creates a statewide small town climate where everyone knows almost everyone else. As a result, since colonial days there is a long standing history of direct, albeit often informal, relationships between state agencies, legislators, and a populace not afraid to speak their minds. This creates an environment of continuous informal feedback that truly helps us keep our "finger on the pulse" of our communities.

We purchase many direct services from vendors in the communities, and this also helps us keep abreast of community needs and concerns. A formal needs assessment is of great importance, but our on-going relationships and ease of communication are also highly valued sources of information.

Our legislators are not career politicians, and there is not a complex political infrastructure. This makes access to leaders and legislators fairly simple and easily accomplished. It is also a strength that our legislative sessions are scheduled to alternate one long year with one short year. While there are great demands on staff to quickly respond to legislators' requests during legislative session, once the legislature adjourns our staff are able to turn their undivided attention to the business of the Division and Bureau. Our legislators are also willing to partner with agencies. For example, one legislator is serving on a Bureau of Health strategic planning work group for Public Health Nursing.

2. Timing

It was fortuitous for FH to be conducting the MCH Five Year Comprehensive Needs Assessment in this current 5 year time frame because the entire Bureau of Health was simultaneously preparing a status report on its Healthy Maine 2000 goals and objectives. Both processes require all BOH divisions to collect, organize, and analyze data for their Healthy Maine 2000 indicators and related program goals and initiatives. Moreover, the narrative section of the Health Maine 2000 status report requires discussion about emerging trends and new challenges confronting the division. Although these concurrent tasks have placed significant additional demands on the FH staff, it has provided an opportunity to review data from across all programs within the Bureau.

3. Collaboration

The collaboration among state agencies, private organizations, and the University is a great strength of this process. Of particular political importance is the participation of the Children's Cabinet. The Children's Cabinet was established by Governor King in 1995 and is composed of those state departments directly related to children and families: Human Services, Education, Mental Health, Mental Retardation and Substance Abuse, Public Safety and Corrections. This Cabinet includes the Commissioners from these Departments. In addition, the Children's Policy Committee and its Childhood Indicators Policy Project, a sub-committee of the Children's Cabinet, has a role in the coordination of policy. This committee is chaired by Randy Schwartz, MSPH the Director of the DCFH. This high

level involvement provides leverage to encourage smaller agencies to participate in the planning process. It also provides us with contacts and data resources in other departments.

4. Maine is a Performance-Based Contracting Pilot State

Maine is one of the states piloting the performance-based contracting concept in their service contracts. A review by the Urban Institute in September 1999 reported that Maine state agency staff report the move to performance-contracting has created a new, outcome-oriented culture at DHS. Contract staff are thinking in terms of outcomes, and providers are requesting assistance with data collection to improve local management practices. Our system is not perfected, but we believe we are steadily moving toward a model program that will benefit all of us: agencies, vendors and consumers.

5. New Bureau and Division Leadership

Since the reorganization of the Bureau of Health, and changes in senior management, a renewed commitment to seriously evaluating programs and their outcomes is evident. Current leaders are not content to do business as usual. Dora Mills, M.D., M.P.H. Director of the Bureau of Health, is a politically astute leader with the skills to effectively advocate with the legislature and public. Randy Schwartz, M.S.P.H., Director of the Division of Community & Family Health, assumed responsibility for this Division after leading another Division responsible for the Bureau's health promotion and education activities. Randy is a catalyst for change, approaching issues without bias and assumptions. Valerie Ricker, M.S.N., M.S., N.P. and Fredericka Wolman, M.D., M.P.H. both bring critical thinking skills and a relative newcomer's ability to ask "Why are we doing this?' when evaluating our program activities. All senior managers challenge staff to think more globally and to actively look for interconnections between programs. A recent example is the identification of common goals and shared target populations surrounding tobacco issues, nutrition and physical activity.

6. Creative Capacity Building

Although severely constrained by the current limitations on hiring staff, we have creatively built critical capacity by outsource contracting with the University of Southern Maine and other entities. Through contracts with the University we have engaged the services of a PhD prepared Chronic Disease Epidemiologist, and are in the process of contracting with a second Master's prepared MCH epidemiologist. We continue to partner with the University on several of their projects.

Weaknesses

1. Multiple Demands

Conducting a comprehensive needs assessment during a time of organizational restructuring and rapid change was challenging. FH leadership and staff were fulfilling the requirements for publishing a Healthy Maine 2000 status report, and planning the Healthy Maine 2010 initiatives, while this needs assessment was underway. These demands, although compatible with the needs assessment, placed added responsibility on an already over extended and understaffed FH team.

2. Time Limits and Competing Priorities

Another weakness in this process was insufficient time to build trust and enhance the communication and collaboration that are essential in forging cooperation among Bureaus, agencies, organizations and stakeholders. There is the ever-present challenge of competing agendas and priorities among the various Bureaus. Compounding competing demands is the fact that many of the federally mandated indicators are inconsistent among Bureaus and Departments. The federal government requires various State agencies to track data for an indicator in slightly different ways. The Bureau responsible for tracking data will compile information in a format that meets their federal mandates, not necessarily the mandates of other Bureaus who need essentially the same data but from a slightly different angle.

3. Staffing Limits

The Bureau of Health has experienced decreases in staffing levels while simultaneously increasing the overall number of programs. Decreased staffing is a result of the 1995 report of the Maine State Productivity Review Task Force, after which the Governor directed an initiative to limit the number of personnel in state government. This staff limitation has become a core element of Maine's fiscal management plan. In addition, the Governor has made a strong commitment to outsourcing. This inability to hire staff is extremely problematic for the Division of Community and Family Health and all other state agencies. This is especially true when one considers the significant impact limiting clerical positions has on program efficiency, and the ineffectiveness of attempting to outsource this key in-house support role. Lack of adequate staff has left positions unfilled, grants unapplied for, and has resulted in existing staff assuming additional responsibilities in addition to their already full-time work loads. It has required a dedicated staff to be creative about accomplishing goals with scarce resources.

4. Technology

Systematically collecting data over time is essential for proper analysis and evaluation of program goals and objectives. Although the Bureau of Health and its FH division has made noticeable efforts in tracking and collecting essential data, the internal capacity for tracking data for all program objectives and related indicators remains outdated and inadequate. Evaluation and data systems in the communities are either limited or do not exist. Our lack of technology is a definite weakness of which we are very much aware. We are doing our best to address this issue under our staffing and resource constraints.

We have established partnerships with several other entities in order to supplement and expand our data resources. We have built partnerships with the following:

1) Maine Health Data Organization which houses hospital discharge information
2) Maine Health Information Center which obtains data from the Maine Health Data Organization and private insurers for large employers. They analyze Medicaid data and can offer some information on utilization and claims.
3) Maine Medical Assessment Foundation, a private non-profit that analyzes data related to Quality Assurance and clinical outcomes. Some of our programs contract directly with them for data analysis e.g. the Lead Program.

4) University of Southern Maine. The University has added biostatistics to their mathematics program and this provides us with a source of interns and hopefully biostatisticians who will remain in the state. The low salaries and lack of an epidemiology program in Maine makes recruitment and retention of biostatistic staff difficult. This program also provides us with a venue for continuing education for our staff.

5) Maine Center for Public Health. This is also a non-profit organization whose mission is to build the Public Health capacity of the state via education and technical assistance. 1996 legislation outlined that there should be such an entity, and provided for some funding. They have hired an executive director, program director, and clerical staff. They plan to work with key staff at the Bureau of Health and with tertiary health care organizations such as Maine Medical Center and community health services.

6) University of New England. This university is working with Harvard School of Public Health and Tufts to bring Public Health courses to the New England region.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of MCH Health Status, Needs, and Priorities

Demographics

In 1998 the maternal and child population in Maine accounted for approximately 48% of the total population of 1,243,316 predominantly Caucasian (98% White) citizens. Women ages 15 through 44 years represented almost 22% (276,187) of our citizens and children ages 0-19 years of age comprised 26% (326,260) of the population. Of those children, 5% (67,147) were 5 years and younger. There were 13,685 live births in 1998. This represents a continued downward trend in Maine of almost 20% fewer live births over the past eight years. In 1998-99 there were 34,306 individuals ages 3-21 with disabilities reported to the Department of Education.

Poverty

The northern two thirds of Maine is rural and poor. The southern third is more urban and has the highest concentration of population, services, providers, infrastructure, and money. However, a 1999 Maine State Planning Office "Report Card on Poverty in Maine" cautions us to remember the differences between Maine's rural north and urban south are not always clearly differentiated. An analysis revealed pockets of distress in prosperous regions and thriving economies in otherwise distressed areas. Though the rate of poverty is highest in rural areas, concentrations of poor—especially within our immigrant population—do exist in the more affluent major cities.

The 1998 report from Maine's State Planning Office shows that Maine's poverty level ranks about 20th among the 50 states and District of Columbia. However, this ranking is very deceptive because Maine ranks 41st in total personal income, 37th in per capita income, and 40th in annual pay of workers. These factors keep many Maine residents on the brink of poverty, even though the state's actual poverty rate remains close to the national average. The number of jobs that pay a livable wage has decreased from 81% of all Maine jobs in 1993, to 67.7% in 1998.

Women's Health: A Maine Profile reports that the unemployment rate among Maine women is about the same as the U.S., but Maine women's earnings are significantly lower than the U.S. average. In 1996 the median annual earnings for Maine women working *full-time* is $16,540. Underemployment is a chronic problem due to the seasonal nature of our economy. In addition, the shift in jobs from manufacturing to the service industry has been accompanied by a decrease in employer provided benefits. The Maine Kid's Count Report for 2000 reports that there are 288,000 children aged 0-17 in Maine and 106,000 (37%) of these children live in families with incomes below 200% of poverty. Seventy-five percent of these children (79,000) have parents who work.

In 1970 family couples made up 72% of all households in Maine. By 1990 only 60% of our households were headed by couples. Almost half (41%) of single mothers with children live at 100% or less of the poverty level and 33% of our women live at less than 200% of the poverty level. It is also important to note that 55% of Maine's women live in rural areas.

In 1999 11.9% of children aged 0-17 received food stamps. During the 1998-1999 school year 31.7% of children were enrolled in the subsidized school lunch program, a percentage holding steady over the past five years. From July 1998-June 1999 there were 85,792 children ages 0-17 participating in Medicaid. Data from the State Child Health Insurance Program indicate that between July 1998 and September 1999 there were 7,000 previously uninsured children enrolled in either expanded Medicaid or the Cub Care Program. (The majority of these were enrolled in expanded Medicaid.)

Regional Disparities

Maine's rural North and urban South socioeconomic disparity creates significant challenges for the Bureau of Health as they work to ensure access to health care services. In the northern two thirds of Maine many pregnant and/or parenting women and children must travel long distances on secondary roads to access services. It can be impossible to make the journey in the winter. If rural clients wish to obtain specialized medical services, such as services related to spina bifida, specialty surgery or audiology, they must travel to either Bangor or Portland. Public transportation (i.e. buses and taxis) is nonexistent in most rural areas, with clients relying on family members, friends or one of the 14 state contracted transportation agencies. While some of these transportation agencies maintain a small fleet of vans, many rely on volunteer drivers using their own vehicles to transport clients. Recognizing the potential for problems with this arrangement, Maine's Department of Human Services (DHS) recently instituted a driver training program for anyone transporting children for the state. This program emphasizes vehicular safety, communication skills, child development and special considerations for children who are in DHS custody.

Another approach used by the Bureau to improve access in rural areas is to bring the service to the client in their home. Our Public Health and Community Health Nurses have traditionally made home visits to clients. However, they are unable to visit every client who needs services. Over the past few years additional home visitation programs have been established in Maine, including Healthy Families, Early Head Start, Parents as Teachers, and Adolescent Parenting Programs. These new programs are indicative of a renewed public and legislative interest in expanding home visitation. There is particular interest in the latest research findings around infant stimulation and early brain development. This has resulted in the allocation of additional funds for home visits

by professionals and mentors. MCH has taken a leadership role in coordinating services in this area and will need to continue in that capacity.

Education

Collaboration between The Maine Women's Health Campaign and the Bureau of Health produced The Status of Women Report. This report reveals that in 1990 (the last year for which data is available) 20.7 % of Maine's women age 25 and older have not completed high school. 38.7% are high school graduates. 23.5 % have one to three years of college and only 17.2% have four years of college or more. The 2000 Kids Count Report shows that in the school year 1997-1998 78.9% of 17 year olds completed high school, a 3.8% increase over the previous year. However for the years 1995-1997, 7% of our teens ages 16-19 dropped out of high school.

Birth Rates/Teen Births

In 1998 there were 13,685 live births. 13 of these children were born to adolescents 10-14 years of age; 1,325 to adolescents between 15 and 19; and the remaining to women over 20 years of age. Of the women 15-19 years of age, 72.9% reported their pregnancies to be unintended and 1,135 (86%) of these children were born out of wedlock. Of those 20+ years of age 30.6% reported their pregnancies were unintended, 2,956 (24%) were born out of wedlock.

In 1998 the rate of births to teenagers aged 10-14 is 0.3 /1000. Women 15-19 years of age is 30.4% Although women less than 20 years of age represent 30.7% of all live births, they represent 86% of out-of-wedlock births; unmarried women in their twenties accounted for an additional 23.9% of out-of wedlock births. The repeat pregnancy rate for the 10-19 year olds is 293.7/1000. These closely mirror national statistics and show that teen mothers continue to have a high percentage of unintended pregnancies and out-of-wedlock births with a significant decline in both unintendedness and out-of-wedlock births for the 20+ year-old mothers.

Prenatal Care/ Low Birth Weights

88.5% of infants born in 1998 were born to mothers who received prenatal care in their first trimester. In 1998 Low Birth Weight infants (under 2500 grams) accounted for approximately 6% of all live births in Maine. Our 5-year average for LBW (1994-1998) is 5.9%, a slight increase from the 1989-1993 average of 5.2% and the 1984-1988 average of 5.1%. Essentially, we have been holding steady at about 6% over the past 15 years.

Very Low Birth Weight babies (under 1500 Grams) accounted for 0.9% of all 1998 live births. Our 5-year average for 1994-1998 is 1.1%. However, 7.5% of births to unmarried women were low birth weight, and babies born to single mothers had a statistically greater chance of being born prematurely.

The latest data from the Office of Data Research and Vital Statistics (ODRVS) (February 2000) indicates that Maine has 114 Obstetricians, 598 Family Practitioners and 59 Certified Nurse Midwives to provide health care services to pregnant women. There are 34 birth hospitals and 2 Level III Nurseries.

Domestic Violence

No research has been conducted that provides a complete assessment of the prevalence of violence against women and children in Maine, but available data indicate it is a serious problem. In 1998 there were a total of 3,853 domestic assaults reported. Of these 2,337 were male assaults on females, 230 parent assaults on children and 213 child assaults on parents. 1073 were classified as "other familial" assaults. Maine also has a high percentage of family violence related murders. In the last 5 years, more than 50% of all homicides were related to domestic violence. According to the report 'Domestic Abuse in Maine", more than 12,000 individuals sought assistance in 1995 from the agencies that are part of the Maine Coalition for Family Crisis Services, and there was more than a 20% increase in the number of petitions for Protection from Abuse.

In his January 2000 State of the State Address, Governor Angus King declared violence against women and children "public enemy number one". Advocates working with family violence responded that Maine's laws in this area are very good. What was needed is consistent and more frequent enforcement by Public Safety and the Maine Judicial System. During the 1999 Legislative session eight new state prosecutor positions were approved specifically assigned to family violence case. Seven positions are funded by the Legislature and one by federal funds.

The Maine Coalition to End Domestic Violence and The Maine Coalition Against Sexual Assault are the two umbrella organizations that oversee services for Maine residents affected by these issues. Direct services are provided by the approximately ten local service providers that form each coalition. Services include a 24 hour crisis hotline, support groups for survivors, advocacy for medical treatment and legal procedures, referrals and educational programs. For victims of domestic violence, services additional services include shelters, a safe home network, and short-term housing subsidies.

Funding is from a variety of sources including the Department of Justice Victims of Crime Act (VOCA) and Violence Against Women Act (VAWA) grants, Department of Health and Human Services Preventive Health and Health Services block grant, United Way and the State of Maine. Funding is coordinated through an administrator in Maine's Department of Human Services. Additionally, the Maine Ambulatory Care Coalition received a three year grant from the Centers for Disease Control & Prevention (CDC) to create coalitions of small towns and villages. These rural coalitions, based in four rural health care centers, provide educational programs and services for victims of intimate partner violence in their under served areas.

In Portland the Family Violence Collaborative, comprised of approximately 100 social service agencies, works with victims of child abuse and neglect, family violence, intimate partner violence and elder abuse. Recognizing that many victims of violence are members of the MCH population, the Bureau of Health recognizes a need for improved coordination and communication with these service providers.

Mortality: Leading Causes of Death in the MCH Populations:

Note: Our small numbers produce a falsely significant statistical variance from year to year. In most cases we prefer to look at 5 year averages for a more accurate picture of trends.

Womens' Deaths

The Maine Department of Human Services, Office of Data, Research, and Vital Statistics reported in Women's Health: A Maine Profile (1994) that the leading cause of death for all women in Maine is heart disease, followed by cancer, cerebro-vascular disease and chronic obstructive lung disease. The leading killer of women ages 25-64 is cancer, with lung cancer the predominant diagnosis followed by breast and colorectal cancer. Breast cancer accounts for the greatest number of newly diagnosed cancer cases among women. The leading cause of death for younger women, ages 15-24 years, is accidents and unintentional injuries. Overall our trends reveal that women who live to be elderly die from heart disease, cancer, cerebro-vascular disease and chronic obstructive lung disease. Women who die mid-life succumb to cancer, and our youngest women die from accidental causes.

Infant Deaths

Our infant mortality rate in 1998 was 6.2 per 1000. This is a slight increase from 1997's 5.1 but, due to the small numerator, is probably statistically insignificant. Our five year average for years 1994-1998 is 5.6. Our 1998 perinatal mortality rate is 8.1per 1,000 live births. and the neonatal mortality rate is 4.2per 1,000 live births The Office of the Chief Medical Examiner reported 15 infants died suddenly and unexpectedly in 1998. Of these, 12 were confirmed to have died from Sudden Infant Death Syndrome (SIDS). Based on preliminary 1998 birth data, this makes a rate of 1.14/1000 live births (0.66/1000 in 1997). The infants that succumbed to SIDS resided in six of Maine's sixteen counties. Birth defects are reported to be associated with 24% of infant deaths in Maine.

Child and Adolescent Deaths

In 1998 Maine's children ages 1-14 years had a vehicle death rate of 2.2/100,000. For adolescents ages 15-21 the death rate increases to 31.0/100,000. Suicide is the second leading cause of death among Maine adolescents and young adults ages 15-24 years of age. In 1998 there were 9 suicide deaths among Maine youths aged 15-19 years (10.1/100,000). This is twice the number of adolescent suicides from 1996 and is higher than the national youth suicide rate. Over the past 10 years, the largest increase in child firearm deaths was due to suicide with 7 out of 10 youths committing suicide with a gun.

Maine has minimal and incomplete data on suicide attempts due to the difficulty in identifying and tracking many incidents that may or may not be intentional attempts to end one's life. However, from 1991-1997 1,764 Maine youths ages 10 –24 years were hospitalized as a result of a self-inflicted injury. In 1998 there were 227 hospital discharges of patients ages 10-24 who had a diagnosis of self-inflicted injury. 80 of these were males and 147 were females.

Maine has been actively addressing youth suicide prevention since Governor King appointed a Task Force in the fall of 1995. The Injury Prevention Program needs to position itself for response to the increase in violence

and intentional injury in our society and state. It is in the process of evaluating its role and identifying gaps in education and prevention services for the MCH population.

Morbidity: Leading Causes of Disease and/or Disability in MCH Populations

Women:

Women's Health: A Maine Profile reports cardiovascular disease, cancer, chronic lung disease and diabetes as the leading chronic and disabling diseases of Maine women. Other conditions include arthritis, asthma, Alzheimer's disease, hearing and visual impairment, chronic bronchitis, and hypertension.

Chlamydia is the most common sexually transmitted disease, followed by gonorrhea. Maine's 1990 baseline was 318/100,000 in the general population and 3,006/100,000 for females ages 15-19.
In 1998 the incidence rate of chlamydia among Maine's general population had decreased to 86/100,000, and for Maine females ages 15 through 19 years decreased to 920 per 100,000.

Maine's 1990 baseline rate of gonorrhea was 18/100,000 in the general population and 61.5/100,000 in youth ages 15-24. In 1998 the rates had decreased to 5/100,00 general population and 19/100,000 for youth.

As of December 1999, 100 Maine women have been diagnosed with AIDS, representing 11% of the 916 cumulative Maine AIDS diagnoses. 51% of women diagnosed with AIDS in Maine cited sex with males as their primary transmission risk. 29% cited injected drug use.

Since 1984, 1% of all Maine AIDS diagnoses occurred in children less than 13 years of age as a result of mother-to-infant transmission. There have been no mother-to-infant transmissions reported to the Bureau of Health since 1996.

Not including mother-to-infant transmissions, 78% of women diagnosed with AIDS were between 20 and 40 years of age. 98% of women diagnosed with AIDS were over 20 years of age.

It is estimated that between 100 and 150 women are living with HIV/AIDS in our state.

Infants, Children and Adolescents

Genetics

In 1998 Maine screened 99% of all newborns for PKU, hypothyroidism, galactosemia, and hemoglobinopathies. In the past two years the Genetics Program has added screening for three additional metabolic disorders to the newborn screening panel. These are Congenital Adrenal Hyperplasia (CAH), Biotinidase, and MCAD. Screening for hemoglobinopathies continue to be done per case on a request basis. The Genetics Program has begun to address emerging needs with the development of a births defects registry.

The Genetics Program is working with audiologists and other interested parties to implement a state-wide bill that will support universal infant hearing screening and intervention with mandated reporting. Currently, routine screening for infant hearing remains on an individual basis, however, the MCH program is not informed if follow-up is provided for positive screenings.

These additional programs and services are needed if we are to continually improve the health status of Maine's infants, but the reality is they also require additional state staff. This program, along with other MCH

programs, struggle with improving and enhancing services while adhering to the state's fiscal management plan limiting the number of state employees.

Lead Inspection Program

The Childhood Lead Poisoning Prevention Program is adjusting its structure and broadening its approach to addressing lead poisoning in Maine. These adjustments are a result of changes in funding allocation as well as a growing public awareness of the seriousness of lead poisoning's negative impact on the health of our children.

Unintentional Injuries

In 1998 non-fatal unintentional injuries to children 14 years and younger were reported by the Maine Department of Human Services ODRVS as 290.6 per 100,000. A five-year moving average shows a steady decrease in the number of unintentional injuries to children ages 14 and younger.

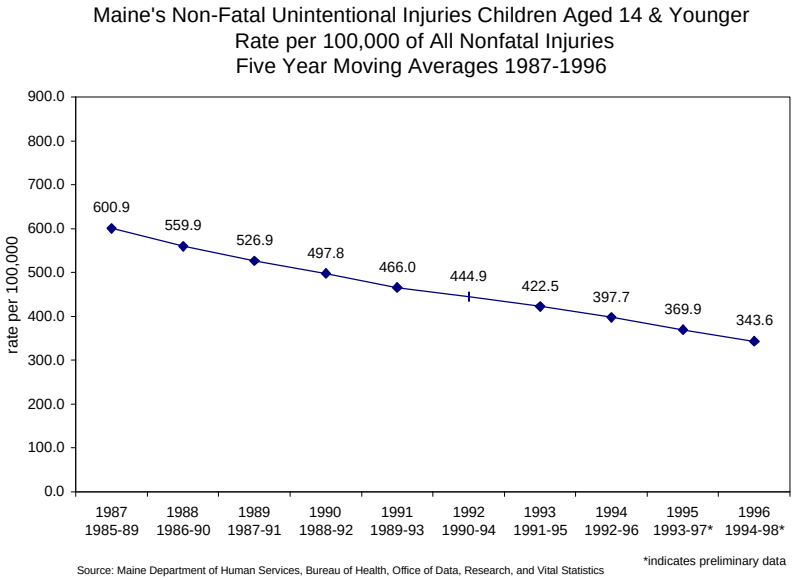


Table 16

For calendar years 1992-1998 there were 135 fire fatalities in Maine. The high rate of injury and death as a result of fire/burn among the very young and very old are of particular concern in our rural state. We postulate this may be attributed to a lack of smoke detectors, dangerous settings heated with wood (i.e. old wooden housing structures and cramped, cluttered house trailers), rural isolation and lack of emergency evacuation planning on the part of our citizens. In August 1997 the Maine Injury Prevention Program (MIPP) received a grant award from the CDC for a 3 year Cooperative Agreement to implement a state-wide fire safety and burn prevention program to positively identify and address these issues.

Youth Violence & Conflict Management

One priority of Governor King's Children's Cabinet is to increase safety for youth in homes, schools and communities. Data from the Maine Attorney General's Office between October 1992 and November 1999 reveals 1,363 complaints were filed related to civil rights violations and bias incidents motivated by religious, ethnic, racial or sexual orientation prejudice. Many of the perpetrators were young men of school age.

The number of juvenile arrests for violent crimes increased steadily from the low of 123 in 1990 to a high of 237 in 1996. In 1997 and 1998 there were declines in the totals of juvenile arrests, which closely mirrors national trends. However, Maine has continued concern about juvenile violence and will continue with programs targeted to decreasing youth violence.

In the 1997 Youth Risk Behavior Survey of 1,837 Maine high school students, 40% of the males and 24% of the females reported being in a physical fight within the past 12 months. 22% reported carrying a gun at least once during the previous month. Almost 15% of those surveyed reported being threatened or injured with a weapon on school property one or more times in the previous year.

All MCH Populations

Nutrition and Physical Exercise

WIC program data indicate that 30% of mothers receiving services were outside normal weight parameters and 51% were inadequately nourished. The 1997 YRBS shows that 30% of Maine's high school students and 29% of middle school students describe themselves as overweight. Almost 50% of our middle school students reported they were trying to lose weight; 66% of these were girls and 33% boys. Their weight loss methods include exercise, taking diet pills, vomiting and overuse of laxatives. 46% of high school students were trying to lose weight with about the same ratio of girls to boys. 85% of middle school students reported attending a physical education class as compared to only 47% of high school students. Maine students' participation in physical education classes declines from 88% of seventh graders to only 14% of twelfth graders. This is probably due to the fact the Department of Education only requires one credit of physical education for awarding of a high school diploma.

PRAMS 1998 data reports that 71.4% of mothers reported initiating breastfeeding their infants. There has been a steady increase in this percentage since 1990 when only 55.4% of new mothers reported initiating breastfeeding. PRAMS 1998 data also reveals 68.7% breastfed for one week or more and 19.3% of all mothers reported breastfeeding for 13 weeks or longer.

As the correlation between the effects of nutrition and physical activity on immediate and long term health status becomes more apparent, the Nutrition Program must take a broader view of their role and build capacity to address these issues in Maine's communities and schools.

Since our 1996 internal reorganization, the Division has diligently worked to establish Nutrition and Physical Activity workgroups. During 1999 the two workgroups were formally combined and have begun developing plans to integrate nutrition across Division programs. The Division is working with the Muskie School to develop a state-wide Physical Activity and Nutrition Plan. The plan development process has brought together traditional and non-traditional stakeholders in order to create a comprehensive and integrated plan. This will be completed in July 2000.

The MCH Program, in partnership with the University of Southern Maine's Muskie School of Public Service, has an initiative designed to provide nutrition education and resources to assist the Food Stamp Program participants to make informed food choices that support optimal health. This coalition, the Maine Nutrition Network, consists of more than 100 private and public sector partners and receives partial funding from the US Department of Agriculture. Activities include the Eat Smart Club Campaign, provision of nutrition education

resources to school teachers, and nutrition education at farmer's markets. The Eat Smart Clubs are an innovative, comprehensive, three-year social marketing campaign to promote healthy eating behaviors, reduce the risk of chronic disease, and promote health in the Food Stamp Program participant population with children less than 19 years of age.

Oral Health

Maine's infrastructure for dental care is minimal. There are two major obstacles to accessing dental care in Maine: a limited number of dental providers willing to accept Medicaid payment (or any form of managed care payment) and a concentration of providers in the southern, more populous and affluent area of the state. Public Health resources for dental care are limited.

According to Women's Health: A Maine Profile in 1995 over 13% of all Maine women had no permanent teeth remaining, 15% of women reported they had not visited a dentist or dental clinic in over five years. According to Maine Kids Count 2000 specific data about numbers of children who receive or lack appropriate dental care are not consistently available. The Kids Count 2000 reported that from July 01, 1998-June 30, 1999 27,174 children covered by Medicaid received dental care from General Dentists. Less than a third of these dentists provided services to more than three-quarters of these children.

The Oral Health Program is positioning itself for response to the public and legislative growing understanding of the relationship between oral health and the overall health of the individual. The program must build capacity in order to continue addressing these longstanding issues.

Substance Abuse

Women's Health: A Maine Profile reports that a 1997 household telephone survey conducted by the Department of Mental Health, Mental Retardation and Substance Abuse Services found that 4.3% (21,000) of Maine women could be classified as needing substance abuse treatment. In FY 1997 2,893 women received substance abuse treatment from publicly funded agencies in Maine. 1,730 received alcohol abuse treatment; 530 drug abuse treatment and 633 received Operating Under the Influence offender program services. Maine women are more likely to be sedentary, obese, and cigarette smokers than women in other states, however, they are less likely to be chronic drinkers.

This same report reveals that tobacco use is the single most preventable cause of death and disease among Maine women. About 21% of Maine women are current smokers and 33% are former smokers. The proportion of women who smoke decreases after age 54, with women ages 25-34 having the highest rate at 29%. Unfortunately, in 1998 35.3% of pregnant women receiving WIC and 37.6% of women whose delivery was paid for by Medicaid reported smoking in the last trimester of pregnancy.

Maine Kids Count 2000 reports that in 1999 (unweighted data) high school students reported via the Youth Risk Behavior Survey (YRBS) the following: alcohol use within past 30 days 52.5% (National 50.8%); Marijuana use within the past 30 days 30.9% (national 26.2%); Cigarette smoking within past 30 days 31.2% (National 36.4%); Use of any form of cocaine within the past 30 days 3.8%; use of any inhalants at any time 16%.

The Bureau of Health's Partnership for a Tobacco-Free Maine program is targeting children and young adults in its campaign to discourage young people from starting to smoke or encouraging them to quit. The program is also targeting the cessation of indoor tobacco use. LD 1349 , passed in the 1999 legislative session and taking effect 9/17/99, has outlawed smoking in restaurants. This expands prior legislation which prohibited smoking in public places.

Behavioral Health

In 1990 under the mandate of a consent decree the Department of Mental Health, Mental Retardation Substance Abuse Services made a switch from inpatient services to community-based services. In 1997 7,873 female Medicaid recipients received treatment for depression and other affective disorders. 1.064 female adolescents and 516 children also received treatment for these disorders.

Maine continues to have problems with access to behavioral care services, especially for children. An effort is being made to increase in-state out patient psychiatric services. In 1999 the Jackson Brooks Institute (JBI), a private mental health facility, declared bankruptcy. JBI was subsequently purchased by Maine Medical Center, becoming Spring Harbor, providing an opportunity for children to be treated in Maine. Efforts to increase in-state outpatient services is also evident in Maine's decreasing out of state placements. In 1999 177 children were in out of state psychiatric facilities, a decrease from 1998 when 186 children were placed out of state. Careful monitoring of children receiving instate services is necessary to ensure adequate access and quality.

Beginning in the Fall of 2000 the Department of Mental Health, Mental Retardation and Substance Abuse Services will no longer provide early intervention services. This important activity will be assumed by the Childhood Development Services system which is administered through the Department of Education.

3.1.2.2 and 3.1.2.3 Direct Health Care Services and Enabling Services

Financial Access

Shifts in Medicaid Coverage

Medicaid Managed Care is currently mandatory following acceptance of the 1115-b Waiver. However, services are offered primarily through the Bureau of Medical Services own PrimeCare, which is essentially a point-of-service plan. PrimeCare is a state run primary care case management program. Providers who contract with the state function as "gatekeepers" and are paid a management fee plus a fee-for-service for any direct services they provide. NylCare entered our Medicaid managed care market in 1997 as a voluntary program, but its share of coverage remains minimal. They currently exist in 7 counties with approximately 2,000 enrollees. At this time the Medicaid Program reports only 55,000 of their 162,000 recipients are enrolled in some form of managed care plan. Unlike some areas of the country where HMO penetration continues to expand, HMO penetration into Maine has significantly decreased. This has resulted in a consolidation of services and merging of local and national HMOs that effectively diminished any local influence on the HMO's. For example, the Maine HMO "Health Source" merged with the large national organization "Cigna" and the locus of management moved to Cigna's national headquarters in Wilmington Delaware and BlueCross/BlueShield of Maine has merged with Anthem Insurance becoming Anthem of Maine with corporate headquarters in Indiana. Both Tufts and Harvard Pilgrim have recently

withdrawn from the Maine managed care market and our HMO enrollment remains limited due to problems establishing provider and service networks. Title XXI, CHIP, also brought changes to Maine's insurance coverage of qualified recipients. Outreach activities, including concerted efforts by caseworkers in the Bureau of Family Independence (BFI) to thoroughly research a recipient's eligibility for Medicaid, have increased Medicaid enrollment to a current unduplicated count of 162,000 recipients. For the state FY99 there were 85,792 children enrolled in Medicaid.

There has also been enrollment in CubCare, our Medicaid-like package of services including EPSDT. Between July 98 and September 99 an additional 7,000 previously uninsured children were enrolled in expanded Medicaid and CHIP. We must continue to monitor this situation to see if our experience mirrors that of some other states' where a decrease in Medicaid enrollment offsets any CHIP expansion.

Also, as medical costs rise and employers shift the cost of health insurance—especially dependent coverage—to employees we may see an increase in the number of working poor and middle class who cannot afford insurance coverage for their children. It is our suspicion that increased premium costs have resulted in a decrease in dependent coverage which in turn has resulted in some increase in CHIP and Medicaid participation. The Kids Count 2000 report suggests that data from the U.S. Census Bureau indicate that 35,000 of the 41,000 uninsured children in Maine live in working families. Of these 35,000 children, 21,000 (60%) live in working families with annual incomes low enough to qualify them for state health insurance programs.

Welfare Reform

Welfare reform has resulted in a decrease in Temporary Assistance for Needy Families (TANF) caseloads over time. From a high of 19,632 cases in January of 1996 to a low of 13, 946 in November 1998. We have also seen the transition of 15,813 individuals to work through the TANF Program. While this may seem laudable, the Conference of Mayors suggests families making this transition may experience an increase in homelessness and hunger, something we must monitor. And we continue to have concern about the availability of services associated with the transition to work, especially availability of child care. The unavailability of child care, especially quality child care, is a growing concern as the number of available child care slots decreases and transitioning off TANF continues. This is an issue we must monitor.

Also, anecdotal evidence suggests households transitioning to work have difficulty accessing specialty services, especially those required by Children with Special Health Needs. This is probably reflective of our dearth of CSHCN services rather than a result of welfare to work initiatives.

Cultural Acceptability

Maine is 98% white with a small minority population that includes four tribes of Native Americans*;* African Americans; South East Asians; Hispanics and our most recent immigrants from Somalia and eastern Europe. We have begun to monitor possible disparities in health care and will further assess this issue with the development of the Maternal and Infant Mortality Review (MIMR). A workgroup within the Bureau of Medical Services arranged for all immigrant children to access services at Maine Medical Clinic's International Clinic where services are

provided by provider teams. We are also working to insure the availability of translation services via individual translators and the ATT Translation Service.

Availability of Services

Availability of Primary Care services continues to vary geographically, with the concentration of services in the lower third of the state. Utilization of Family Planning services has declined and it is unclear if this is a result of HMO's offering similar services, or if clients (especially teens) are not using services. Our teen pregnancy rate remains low, but we must continue to monitor this trend especially given the decrease in attendance at Family Planning sites.

We have made a commitment to home visiting programs with increased support from the Task Force on Early Care and Education. This task force successfully lobbied for comprehensive home visits for all newborns in Maine. We are currently making funds available for development of services consistent with the curricula/program content of Healthy Families or Parents As Teachers. We are developing an RFP for expanding our home visitation program.

Specialty Services

MCH continues to offer assistance with access to specialty services, especially for Children with Special Health Needs. Clinics are funded for Spina Bifida, Cleft Lip and Palate, and Metabolic Clinic. These clinics have successfully offered statewide comprehensive services via a team approach. We are in the process of evaluating the feasibility and value of offering mobile services that will bring specialists to the more rural regions of the state. There is also an effort underway to maximize access to limited resources while avoiding overlapping services. We have seen improved communication among providers, but must continue to monitor usage as competition increases while resources and funding decline.

Standards of Care/Quality Assurance/Research

All HMO's doing business in the state have adopted the Bright Futures Guidelines and produce physician report cards as part of an on-going monitoring system**.** Maine Bureau of Medical Service's Medicaid is unique in having developed physician report cards for their enrolled providers. This system has been heralded nationally as a means to monitor quality and provide compensation to those practitioners providing good preventive care services. Research continues through private/affiliated studies including an asthma study with the Maine Medical Pilot Program. This program is testing a model for optional care appropriate for treatment in rural areas. We are currently exploring opportunities to enhance school/hospital/provider and Bureau of Health local coalitions with the American Lung Association of Maine (ALM), Maine Medical Center (MMC) and the Bureau of Health through Robert Wood Johnson Foundation and Center for Disease Control grant opportunities

We are continuing to monitor selected aspects of care, especially family services and child protective services (CPS) through the Child Death and Serious Injury Task Force and other work groups. We are also developing monitoring systems for selected cases of morbidity and mortality. Additionally, the Family Health

Programs are working to more fully integrate the issues of quality improvement and assurance throughout the MCH programs. We have applied to the Association of Maternal Child Health Programs (AMCHP) for technical assistance (TA) to formally address this issue. If our application is successful, we anticipate the TA will begin Fall 2000.

3.1.2.4 Population-Based Services

Table 17

Pregnant Women, Mothers and Infants					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Birth Defects Surveillance	The Genetics Program is developing a surveillance system to collect data on the occurrence of birth defects in order to better analyze data for prevention, improving access to services and program planning. Currently there is not a state-wide surveillance system for birth defects.	Program still in development. Birth hospitals will be responsible for reporting the occurrence of specific birth defects in an infant or fetus. The Program will link reports with other data, including vital records and clinical data. Referrals for services will be available through PHN or CSHCN.	State coordinates with hospitals, health care providers, genetics agencies, specialty clinics, vital records, PHN, CHN and families.	Statewide	State funds CDC
Breastfeeding Programs	The goal is to ensure that women, families, and clinical providers in Maine have access to current, accurate information and technical assistance to make informed choices regarding breast feeding. Also access to support and clinical assistance if breastfeeding problems arise.	Services are provided by PHN/CHN, hospital staff and staff from other programs.	Coordinate with WIC, PHN, CHN, Nutrition, Maine Breast Feeding Coalition.	State-wide Coalition has regions that match the PHN regions.	Federal USDA WIC, MCH Block Grant

Pregnant Women, Mothers and Infants continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Child Traffic Safety	The goal of this program is to prevent serious traffic-related injuries and deaths to Maine's children by increasing the number of children served by the child safety seat loan programs, extending availability of special needs restraints, dissemination of educational material and resources, and provision of technical assistance.	Provide annual trainings, technical assistance, and resources to child safety seat loan programs.	Coordinates with MTSC. The Bureau's representative is a key member of the MTSC Board of Directors and participates on several work groups. Also coordinates with various agencies and programs including safety seat loan programs, law enforcement, fire personnel and medical professionals.	State wide	MCH Block Grant and Bureau of Highway Safety
Comprehensive Genetic Services	Our goal is to ensure that families and individuals in Maine have access to comprehensive genetic services that enable them to reach informed choices and increase their ability to live healthy and productive lives. We screened 13,541 infants in 1998 for PKU, hypothyroidism, galactosemia, homocystinuria, Maple Syrup Urine disease, biotinidase deficiency, MCAD and hemoglobinopathies. In October 1998 (FY99) we added screening for Congenital Adrenal Hyperplasia to our test screen panel. 100% of Maine infants with positive test results were receiving proper treatment within one week of diagnosis. No other entity provides these services.	Birth hospitals have responsibility for specimen collection. The State assures all infants are screened & report all screening test results to medical providers and hospitals. State is responsible for tracking abnormal results until a diagnosis is confirmed and the child receives therapy. State is a resource for technical assistance and problem resolution. The CSHCN Program holds a Metabolism Clinic.	Coordinates with genetic specialists, agencies, hospitals, laboratories health care providers and families. The Genetics Program provides grant funding to three agencies that provide comprehensive genetic services, including risk assessment, laboratory and clinical diagnosis, genetic counseling, case management/referral, and education to providers and the public.	Statewide via outreach clinics and education.	Hospitals/ providers are charged $26.75 per specimen for Newborn Screening. This funds lab, UPS contracts, and salary of program manager. Daily program costs funded by MCH Block Grant. Grants are funded by state monies. MCHBG funds are used for coordination and education.

Pregnant Women, Mothers and Infants continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Family Planning	Maine youth initiate sexual intercourse at a slightly higher rate than the national average. This rate increased slightly from 1995 to 51.6%.	We grant funds to the Family Planning Association (FPA) of Maine and have sole responsibility for management of these grants.	We coordinate with the FPA who in turn coordinates with the direct service providers. Adolescent sexuality issues are also addressed through Family Life Education consultation, HIV Prevention Education, and the Abstinence Media Campaign.	Family Planning services are available in 32 clinics throughout all of Maine's 16 counties.	Title XX Social Service Block Grant, state funds. There is no direct funding from Title V MCH Block Grant
Healthy Families Referrals	The goal is to ensure that families desiring support via home visitations have long-term access to programs such as Healthy Families, Parents as Teachers, Parents Are Teachers Too and/or PHN/CHN. In FY1999 513 families were served through Healthy Families	We currently grant funds to Healthy Families sites. In FY01 we will also fund Parents as Teachers, and Parents are Teachers Too sites. We have sole responsibility for management of these grants.	We coordinate with the program managers of the funded sites, PHN and CHN.	Healthy Families is currently limited to 6 pilot sites. PHN/CHN available statewide dependent upon caseloads and staffing numbers. With FY01 expansion we expect most first-time families will have (if they choose) home visitation services.	State general fund and MCH Block Grant.
Infant Mortality Review	In development				

Pregnant Women, Mothers and Infants continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Multidisciplinary Review on Child Death & Injury Due to Abuse/Neglect	Multi-disciplinary Legislative Task Force empowered to review child deaths and serious injuries in Maine.	MCH Medical Director and PHN Nurse supervisors serve as representatives from BOH.	Task force membership is multi-disciplinary and includes law enforcement, Medical Examiner, BOH, CPS, and state forensics.	State-wide	Legislative funds
Newborn Hearing Screening	Routine newborn hearing screening in Maine has been adopted on an individual hospital basis. In CY98 nine of the thirty four birth hospitals in Maine performed some form of hearing screening. Six of these screened all newborns and three screened infants "at risk" for hearing impairment. 12 other facilities are planning to initiate hearing screening. The Newborn Screening Program is evolving. A workshop was held in April 2000 to provide a forum to discuss newborn hearing screening. It was attended by 122 people. Major concerns identified were (1) cost of equipment and (2) lack of infrastructure to provide comprehensive audiologist evaluation and intervention in rural areas. Division staff have met with advocates and providers to discuss these issues.	Once a tracking system is in place, hospitals and providers must report results to the Newborn Hearing Program. The Program will provide technical assistance and will be responsible for tracking to ensure hearing impaired infants receive appropriate interventions.	The program manager for the Genetics Program has participated in discussions with audiologists regarding implementation of a statewide initiative and a legislative bill has been introduced. LD 1814 requires hospitals to provide information to new parents about hearing screening and intervention. If the hospital does offer screening, they must refer the family.	Southern portion of the state only at this time. Goal is to become statewide.	Funding being sought.

Pregnant Women, Mothers and Infants continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Oral Health Program Grants	With a minimal public infrastructure for the delivery of oral health services, there is a need for the provision of consultation and technical assistance to government agencies, non-profit organizations and other groups to facilitate access to and delivery of quality oral health care services in all areas of Maine. Schools and community agencies have received funding as well as consultation and technical assistance to assist them in delivering clinical services and implementing oral health promotion activities and educational programs.	We grant funds to 3 community agencies to assist funding of 4 non-profit dental clinics. We also fund two community agencies to provide community oral health promotion, education and disease prevention activities, and to support local school-based oral health education programs. We've made occasional mini-grants to assist community groups with capacity-building efforts. The OHP will be responsible (as of 7/1/00) for developing and administering a significant program intended by the state legislature to help develop and expand community-based oral health programs, and also provide subsidies to offset sliding fee scales.	We provide technical assistance and consultation as needed and participate in a number of workgroups and committees both within and outside of state government that have mutual concern.	Current grants for clinics are made to agencies designated by the legislature and are not competitively awarded. The geographic distribution is uneven. The two current community agencies are located in two of Maine's most rural and under served counties, and funding is essential.	MCH Block Grant, state funds, and Preventive Health & Health Services Block Grant

Pregnant Women, Mothers and Infants continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Perinatal Outreach	Provide consultation regarding perinatal issues including transport to birth hospitals and providers as requested.	Acting Program Manager oversees contract for services with Maine Medical Center Perinatal program.	Serves as liaison to any agency requesting assistance. (Will be central/critical in development of Maternal/Infant Mortality Review System.)	Statewide	MCH Block Grant
Preventive Dental Programs in WIC	This program provides parental education, toothbrushes and fluoride supplements as appropriate (based on fluoride level in home drinking water) to children ages birth to 5 participating in DHS-sponsored Well Child Clinics. The program was implemented about 15 years ago to provide oral health education and fluoride to a population group that might otherwise have not received it.	Services are provided by PHNs on site with administrative support (record-keeping and materials) provided by the OHP.	At one time, the Preventive Dental Program was also offered in Well Child Clinics sponsored by community agencies, but this relationship has not continued.	The Preventive Dental Program was offered at all "full-service" Well Child Clinic sites. With declining enrollment in the program statewide, there are fewer sites and fewer children participating.	MCH Block Grant and Preventive Health & Health Services Block Grant.
Public Health Nursing (PHN)& Community Health Nursing (CHN) Referrals	PHN/CHN goal is to ensure that women and families in Maine have access to pre/post natal care and pediatric care. They also ensure that clients have sufficient information to make informed choices for themselves and their families.	Services are provided directly by PHNs and via contracts with CHN agencies. These contracts are managed by Family Health.	Coordinate with Community Health Nursing agencies.	State-wide	MCH Block Grant and state funds

Pregnant Women, Mothers and Infants continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Shaken Baby Education	Head trauma is the leading cause of death for infants and small children. SBS Specialist functions as a resource providing expertise and materials to appropriate parties for increased prevention education..	Staffed by SBS Specialist within Maine Injury Prevention Program. MIPP provides prevention ed upon request to any agency, group or organization in the state. Also coordinates a one-day informational conference for individuals who have regular contact with infants and small children. Program works directly with parents of SBS victims.	Coordinate with interested parties including parents, Child & Family Services, Public Safety, Corrections, Health Centers, Day Care Providers, Hospitals, Public/Community Health Nurses, Physicians, Child Abuse & Neglect Councils, Health Educators, Community Action programs, Child Development Resource Centers, Community Counseling/Foster Parent Programs, etc.	Statewide	CDC Prevention Grant funds
SIDS	PHN and CHN accept referrals from the Chief Medical Examiner's Office to contact families with a child that may have been at SIDS death. Referrals are made with days of the death in order to provide timely support and information to the family via PHN/CHN. On-going support is offered throughout the grieving process. Also coordinate workshops to update the greater provider community regarding SIDS research and prevention initiatives.	The CME office makes referrals to Public Health Nurse Supervisor who is designated as SIDS contact person for the state. This person is the liaison for information between the CME office and the staff nurse working with the family.	Coordinate with CME Office, Bureau of Child & Family Services, Public Health Nurses. CHN, Law Enforcement, Emergency Medical Services staff, and the Child Death and Serious Injury Task Force.	State-wide via PHN/CHN	MCH Block Grant and General Fund

Children & Adolescents					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Child & Youth Injury Prevention Activities	Unintentional injury is the leading cause of death and disability among Maine children aged 1-24. This program's goal is to decrease the incidence of unintentional injuries to children and youth.	The MIPP provides funding to five Safe Communities Coalitions. Also contract with the Maine Poison Center to provide education and outreach about both intentional and unintentional poisonings.	Coordinate with the Safe Communities Coalitions who in turn work with their constituents at the local level. We coordinate with PHN to disseminate educational information. Program staff make presentations and provide training to groups and organizations.	State-wide	Bureau of Highway Safety and MCH Block Grant
Fire Safety	Statistics show that children age 5 and under and the 65+ population have a significantly greater risk of dying in a residential fire. The MIPP works with fire departments and other CBOs to promote fire-safe practices among these at risk groups. PHN: The goal is to include fire safety as part of the PHN assessment and education of clients. We also assist with enrolling participants in the fire grant and monitoring if the smoke detectors were installed.	We are working to position ourselves as a credible partner in the promotion of residential fire safety. PHN does fire safety assessment and education.	Highly collaborative with Mine Fire Service and CBOs interested in the issues of residential fire safety. Coordinates with the Injury Prevention Program.	State-wide	CDC grant, MCH Block Grant and State funds

Children & Adolescents continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Lead Screening	Lead surveillance and monitoring throughout the state.	Do not provide direct services.	Coordinate with PHN for case management services for lead poisoned children and their families; coordinate with private lead inspectors for environmental investigations; Department of Environmental Protection for regulation abatement activities; Maine State Housing Authority for financing of lead abatement work; HETL for blood lead analysis; and Muskie School for health education.	State-wide	CDC and State General Fund
Nutrition	The MCH Nutrition Program promotes good nutrition and healthy lifestyles for Maine's MCH population. The Program is also involved with the Maine Nutrition Council, a statewide nonprofit organization that promotes nutrition education.	The Program serves as grant manager and Bureau liaison for the Maine Nutrition Network. The Network is a statewide organization of public and private partners formed to promote nutrition messages consistent with the Dietary Guidelines for Americans and the Healthy People 2010 objectives.	Collaborate with the Maine Nutrition Network and the Maine Nutrition Council.	State wide	MCHBG

Children & Adolescents continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Peer Leaders	Peer leader programs decrease adolescent risk behaviors by promoting leadership development and aspirations. Maine Youth Suicide Prevention Program also supports peer mediators in selected schools.	We manage a grant with Peoples' Regional Opportunity Program (PROP) in Portland.	Grantee provides training to local peer leader programs in other departments.	Approximately 100 programs state-wide.	State funding
Primary Prevention of Teen Pregnancy	Community and school programs to reduce teen risk behaviors and prevent teen pregnancies. The goal of these programs is to decrease the school drop-out rate, decrease pregnancy rates by 50%, and increase mother-daughter communication. Maine continues to have a decrease in the number of teen pregnancies, birth rates and abortion rates. Abstinence Only media campaign, Family Life Education Consultants through FPA also provide services in this area.	We grants funds to two community agencies and also mini-grants to FPA.	We coordinate with the FPA who in turn coordinates with the direct service providers.	Two grants serve 3 communities; mini-grants serve 5 communities. Coverage is scattered across the state.	State funds

Children & Adolescents continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
School-Based Health Centers (SBHC)	National data shows that teens are the most under served age group for both preventive and acute health care. Maine had very few teen health specialists and few clinics with teen walk-in hours. School health clinics are a point of access for comprehensive health care. In addition, these clinics are the coordinating agent between the school health clinics and the adolescents medical home.	SBHCs are sponsored by local medical organizations and receive reimbursement from Medicaid and CubCare.	We coordinate with local medical providers and the Bureau of Medical Services.	There are 15 SBHC located throughout the state.	MCH Block Grant and State funds.
School Oral Health Programs	School Oral Health Programs provide classroom-based education, fluoride mouth rinse, and increasingly dental sealants (for 2nd grade students) in grades K-6. A major incentive for the program at its inception 20+ years ago was to provide the fluoride component. Schools must have a 30% free and reduced lunch rate to participate, and priority has been given to schools in non-fluoridated communities. Schools receive small grants on a per-capita basis to support these programs. Participation in this program has been relatively consistent, with about 40% of Maine's elementary school students involved.	OHP staff manages small grants to individual schools, school districts and several agencies on behalf of schools. There are roughly 80 grants per year in recent years, involving about 250 schools. The OHP coordinator provides consultation and technical assistance to local program directors throughout the school year, and provides an annual training meeting each fall.	We will provide consultation, technical assistance and materials to any school in Maine on request. Staff work with the Coordinated School Health Program and other groups to include and integrate oral health education into comprehensive school health education curricula.	Participation in the School Oral Health Program is voluntary. However, there are participating schools in all of Maine's 16 counties.	State general fund for school grants and bulk purchase of fluoride mouth rinse. Health educator/RDH program coordinator is paid via the PHHS Block Grant. MCH Block Grant and state MCH match used for sealant component.

Children & Adolescents continued…					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
Youth Suicide Prevention	The Maine youth suicide rate is higher than the national youth suicide rate. This program is a program of Gov. King and the Children's Cabinet. Goals are to reduce the incidence of suicidal behavior among Maine Youth 10-24 years of age and to improve youth access to appropriate prevention and intervention services.	Commissioners and Senior Staff from Departments of Human Services, Education and Mental Health/Mental Retardation/SAS, Public Safety and Corrections cooperate to strengthen the state-supported infrastructure of service provider agencies and schools with a statewide crisis hotline, a statewide information resource center, training and technical assistance.	Gatekeeper training is offered via a contract with Medical Care Development, Inc. Program reaches medical professionals, college communities, clergy and substance abuse counselors.	State wide via gatekeeper training and other agencies directly involved with youth.	Children's Cabinet, DMHMRSAS, DHS and DOE, a federal grant for school-based school-linked mental health services, a federal Emergency Medical Services for Children (EMSC) grant and private contributions.
Youth Violence Prevention	Maine youth do not experience violence at the same level as their urban counterparts, but violence remains a concern. Per the 1997 YRBS 40% of male and 24% of female students reported being in a physical fight within the past 12 months. Data from the AAG shows incidence of hate crimes is on the rise. This program's goal is to decrease violence among our youth and to monitors youth violence incidents and trends.	Program provides two universities with grants to provide youth violence prevention training. Provides a grant to the Attorney General's Office to set up a Civil Rights Team. Developed a website for dissemination of youth violence prevention information.	MIPP provides funding for annual conference for school personnel to increase their knowledge and ability to integrate violence prevention practices into the educational setting. Cooperative agreements with two universities assist schools to establish school-based peer mediation and/or conflict resolution programs.	State-wide	MCH Block Grant and Preventive Health & Health Services BG

Children with Special Health Care Needs					
Program Name	**Program Description and Need for Specific Services**	**State's Involvement in Direct Management of These Services and Programs**	**State's Involvement in Coordination with Other Agencies of These Services and Programs**	**Geographic Availability and Distribution**	**Funding mechanism**
CSHCN Occupational Therapist	Serves as case coordinator for children with multiple disabilities, especially those that are musculoskeletal in nature.	No direct services, case management only.	Coordinates with Department of Education, Nutritionists, Speech and Language Therapists, Social Workers and other Occupational Therapists.	State-wide	MCHBG
Outreach Workshops on Cleft Palate	Workshops conducted by CSHCN Coordinator. Hospital-based trainings for Maternity Ward staff to improve their ability to recognize and refer children with cleft palates to the CSHCN Program.	Conduct the workshops.	Coordinate with hospital administration, staff and PHN.	State-wide	MCHBG

3.1.2.5 Infrastructure Building Services

Maine state government has a lean state employee-based infrastructure with very minimal local or county health department presence. Historically, provision of services to our citizens is via public-private partnerships with the state agencies providing funds and private sector agencies/individuals delivering direct services. (In some instances the private sector does obtain additional funds for augmenting specific services.) Service delivery by community agencies allows for tailoring of services specific to population needs and attention to targeted at risk groups.

The coordination of services across funding sources, state departments, and geography is the biggest challenge to achieving an efficient and comprehensive system. Programs serving the maternal and child health population are housed in many different departments including the Department of Human Services, Bureau of Health; Child and Family Services (in particular child support and child protective services); Bureau of Family Independence (eligibility for Medicaid, TANF and the Food Stamp Program); Bureau of Medical Services (administration of Medicaid and CHIP); and the Office of Day Care and Head Start. MCH population programs are also with the Department of Corrections; Department of Mental Health Mental Retardation and Substance Abuse Services; Department of Public Safety (which includes the emergency medical system and pediatric EMS); and the Department of Education Child Development Services and Coordinated School Health. The complexities of such a broad delivery system has led to efforts to coordinate service delivery. For example, Maine is one of 15 states awarded a CDC Coordinated School Health Infrastructure grant. This program is jointly staffed by the Department of Human Services (Bureau of Health) and the Department of Education. Work commenced in the spring of 1999. While efforts have focused upon developing a foundation among the many programs working with this population, fruit of their labors are beginning to become evident.

Additional collaboration includes the Integrated Case Management System (ICM), a Commissioner level initiative to coordinate agencies and personnel providing case management to families and individuals at risk. The Early Care and Education Task Force also represents a government wide initiative to provide home visitation to all newborns and their families. The system developed supports local development of programs aimed at meeting community needs with centralized support for standards and evaluation of Continuous Quality Improvement primarily provided by MCH.

Preventive and primary cares services for pregnant women, mothers and infants:

Services for prenatal and postpartum care are provided through private provider practices (OB/GYN, family practice, nurse practitioners, and midwives), federally funded health centers, city public health clinics, and hospital based clinics. Additional preventive and support services are provided in the home via Public Health Nurses, contracted Community Health Nurses, and home visitation programs such as Healthy Families (HF), Parents as Teachers (PAT), Parents Are Teachers Too (PATT), and Cooperative Extension nutrition education programs. Monies from Maine's Tobacco settlement have been appropriated for the expansion of home visitation via the HF,

PAT, and PATT models. As the number of home visit providers increase, agencies (state and community) must remain diligent about identifying and preventing duplicative services.

Primary and preventive care services for infants are provided through private provider practices (by physicians, nurse practitioners, and physician assistants with specialization in pediatrics and family practice), hospital based clinics, and some well child clinics (WCC) organized by Public and Community Health Nursing. As the proportion of Maine residents with insurance coverage increases via the expansion of Medicaid and SCHIP (Cub Care) and employer based managed care plans, the attendance at WCC has decreased. The DCFH is evaluating the WCC service delivery model and the capacity among providers in the surrounding communities to assume responsibility for the children who currently continue to seek care in the well child clinics. This reflects our desire to move from the direct service WCCs to facilitating care access through vouchers and referrals to local PCPs. If found appropriate by review, this approach will also enhance continuity and coordination of care at the local level. Additional preventive care services are provided via home visitation programs as listed above.

Preventive and primary care services for children

As with infants, the provision of preventive and primary care services are provided primarily by private provider practices composed of physicians, nurse practitioners, and physician assistants with specialization in pediatrics and family practice. The WCC listed under infants also serve children through age 5, with a few serving children through 12 years of age.

Services for CSHCN

Primary and Preventive care services for this population are provided by pediatric and specialty providers. The state CSHN program pays for specialty services for income eligible clients (currently up to 250% FPL). In addition, the program coordinates and staffs 3 specialty clinics (2 for cleft lip and palate and 1 for Metabolism) and ensures, through grant monies, the provision of specialty clinics for Spina Bifida, PKU, and Developmental Evaluation around the state.

Staff in the CSHN program provide case management to all program clients. The PHN and CHN programs provide assessment and preventive education to CSHN clients via home visitation. The CSHN program works with the nursing programs, especially PHN, to ensure the nurses are up-to-date regarding standards of care and current research. The CSHN and PHN programs have developed a team of specially trained nurses to function as resources to the other PHN and CHN nurses. Key collaboration/cooperation with local Primary Care Providers is critical to assuring statewide access and quality of services to children with special health care needs. Programs such as AAP Medical Home Project and coordination with New England Rural Pediatric Associates are aimed at addressing access and quality issues. The newly revived CSHCN Parents Advisory Board also provides group input critical to achieving essential levels of quality service.

Women, Infants and Children (WIC)

WIC's position within the Family Health program helps to ensure their investment and participation in MCH issues. They routinely work closely with the CSHCN and Genetics programs to help insure access to nutrition

education and supplements critical to the well-being of citizens at risk. They also routinely collaborate with the MCH Nutrition Program, PHN, and the Home Visiting programs.

Maine's Adolescent Transition Program (MAT)

Maine's MAT represents an ongoing initiative to partner with key stakeholders, family advocates, and consumers regarding adolescents and young adults with special health care needs. University of Maine Center for Community Inclusion as well as representatives from Family Voices, Department of Education and the Department of Mental Health, Mental Retardation and Substance Abuse Services all work together to address the needs of this population.

Evaluation and CQI

The FH Program routinely evaluates programs and strategies. Most recently, there has been an effort to incorporate CQI into ongoing program activities. Indeed, AMCHP technical assistance requests specifically address the need and desire for staff education regarding those critical public health functions.

3.2 Health Status Indicators

See Form # 14

3.2.1 Priority Needs

Attention to five global priority areas for focusing our human and financial resources is critical to achieving our vision. These areas are:

1) Building systems and community capacities
2) Initiating and advocating for public health policy
3) Developing and delivering programs and services
4) Collaborating with others
5) Providing leadership

The Strategic Planning process brought into focus five additional overarching priorities that will require on-going efforts over the next several years.

6) Establish the Maternal & Child Health Advisory Committee
7) Improve nutrition and physical activity for the MCH population
8) Enhance Teen Health initiatives and programs
9) Integrate MCH activities with Tobacco Cessation and Prevention Activities
10) Coordinate across Divisions and Programs on common issues

Table 18 Matrix of Specific Stakeholder Identified Needs that can be addressed in the shorter term:

MCH Population Needs As Identified in Needs Assessment Focus Groups			
	Pregnant Women, Mothers & Infants	***Children & Adolescents***	***Children with Special Health Care Needs***
Direct Health Care Services Personal care services	Mentoring via Home Visits Mental Health Services	Mental Health Services Substance Abuse Treatment & Prevention School-based Health Clinics	Mental Health Services Continuation and Expansion of Specialty Clinics Comprehensive Medical & Developmental Services Occupational/Physical/Speech Therapy Hearing Screening
Enabling Services *Assist eligible Maine citizens to access health care, health information and health services.*	Transportation Affordable, Quality Child Care	Transportation Sexuality & Reproductive Health Education	Northern Maine Access to Services
Population Based Services *Preventive and Personal health services available to all MCH populations,*	Universal Parenting Support Domestic Violence Services	Enrichment Programs Life Skills Education	Enrichment Programs Feeding Support for Premies
Infrastructure Building Services *Programs and activities to develop, support and maintain access and quality services.*	Dental Access Affordable & Adequate Health Insurance	Dental Access Safe Places Before/After School with alternative recreations	

A listing and discussion of existing Preventive and Primary Care Services may be found in Section 2.4 :

Brief Discussion of Stakeholder Identified Needs (see Table 18 matrix previous page):

Population #1:Pregnant &Parenting Women, Infants

Note: At the Strategic Planning Forums where the discussion centered around pregnant and parenting women, our stakeholders chose to encompass a broader population including all women of reproductive age.

Direct Services **Identified Need #1*: Mentoring Via Home Visitation***

Discussion

Stakeholders believe all parents of newborns, regardless of the family's economic status or the number of previous children, should have access to parental support services. There was considerable support to focus on early brain development and the importance of infant stimulation. Maine has several programs already working with this issue including the Public Health Nurses, Healthy Families Program, Parents As Teachers, and Early Head Start. All of these entities provide parental support, but to prescribed clients, not all parents.

The MCH program must develop and model collaboration between home visiting programs, nutrition programs, tobacco cessation and prevention programs. We must use school-based and school-community linked approaches to delivering services.

The first year of Governor King's administration brought together a task force to study the advisability of expanding home visitation services in Maine to include the *Healthy Start* (aka Healthy Families) model. In the 1996 legislative sessions funds were appropriated to institute a four year, three site, pilot project of *Healthy Start*. In 1997, publication of new research demonstrating the importance of early brain development, broadened the interest in home visitation and early infant stimulation. Ultimately, sufficient funds were appropriated in 1997 (FY98) to fund a total of six pilot sites. In Maine, receipt of home visitation services is voluntary.

In 1999, the Early Care & Education Task Force successfully submitted legislation to expand home visitation using the Healthy Families *Parents as Teachers* and *Parents are Teachers Too* models. Beginning in FY01, at least $4.8 million of Maine's Tobacco Settlement funds will be available via an RFP process to support the expansion of home visitation services. While the long-range goal is to make these home visitation models universally available to all families, the current funds will only be sufficient to provide services to about 80% of Maine's first-time families.

Family Health's challenge is to implement an expansion of these new home visitation programs that coordinates with existing programs such as Public Health Nursing, Community Health Nursing and Early Head Start. An additional challenge is the development of an evaluation system for these similar yet different models.

Direct Services **Identified Need #2: Genetic Services**

Discussion

During the MCH Strategic Planning process, a series of stakeholders meetings were held. Several comments were received that relate to provision of comprehensive genetic services.

- Transportation
- Access to specialty services,
- Increase availability of specialized clinics (all areas of the state)
- Team based services
- Prevention

- Early identification of those at risk for problems (i.e., birth defects, other health problems and developmental delays) preconception and pregnant women, children and other individuals
- Care coordination/case management
- Early intervention services
- Resource Directory-web based
- Evaluation of programs and services
- Education for providers and public

In reviewing past grants and reports, we noted a decrease in the number of index patients and that the projected numbers of patients was not reached. Perhaps projections were not reached because individuals and families are struggling to "get by" and genetic evaluation with the associated time and travel distance for genetic services is not a priority. Other causes may relate to capacity of agencies with limited resources for "marketing" services or long waiting times for non-urgent clinic appointments. A particular need is for dissemination of information and services related to prevention, preconception, prenatal and genetic risk assessment and integration of genetics into medical care.

Direct Services **Identified Need #3: Mental Health Services**

Discussion

Mental health services are inadequate in two major ways:

- First, women with diagnosed mental illness have difficulty accessing services.
- Second, access to preventive mental health services for adults and children is limited by too few providers and high cost.

Enabling Services Identified Need #4*:* Transportation

Discussion

This area has two major problems. First, the logistics of transporting clients over long distances. Clients related difficulties making reservations for trips and also problems communicating any changes in plans to the drivers. The second transportation issue is insufficient funding. Transportation programs and the Bureau of Health identified that there is insufficient funding for non-Medicaid eligible special programs. There is also a lack of adequate funding to provide more reliable and accessible transportation across the state.

Enabling Services Identified Need #5*:* Affordable, Quality Child

Discussion

Clients reported a lack of quality child care services both for work time and for outside appointments.

Population-based Services Identified Need #6: Family (Domestic) Violence

Discussion

Clients in focus groups reported difficulty accessing services and finding providers comfortable dealing with domestic violence issues.

Population-based Services Identified Need #7: Universal Parenting Support

Discussion

Maine has several programs already working with this issue including the Public Health Nurses, Healthy Families Program, Parents As Teachers, and the Early Head Start. All of these entities provide parental support, but to prescribed clients, not all parents.

Population-based Services Identified Need #8: Affordable Health Insurance and Adequate Coverage:

Discussion

Unless women are pregnant or newly post-partum, they are not eligible for Medicaid coverage. This is particularly hard on the working poor. Medicaid eligibility for pregnant women is now up to 200% FPL. Focus group participants requested an insurance coverage similar to Maine's Cub Care for women of reproductive age who are otherwise uninsured. Beginning 9/00 (through the Tobacco Settlement funds) parents of children insured through Medicaid will be eligible for Medicaid insurance. The eligibility limit for parents will be 150% FPL.

Infrastructure Building Services Identified Need #9: Dental Access Services: Women of reproductive age

Discussion

Medicaid has a very limited number of providers willing to accept Medicaid payment. In addition, there is not a good geographic distribution of dental providers throughout the state with most providers concentrated in the southern region of the state and few providers in northern areas.

Population #2: Children and Adolescents

Needs identified during the strategic planning process for both children and adolescents mirrored the needs identified for pregnant and parenting women.

Direct Services Identified Need #1: Mental Health Services

Discussion

Common to all populations, a need for additional mental illness treatment and prevention services. The need for professionals trained in child development and able to work with the pediatric population was identified. Also needed are family stress management programs and courses. There was support for creating programs that enhance a healthy, nurturing, and safe environment for children.

Direct Services Identified Need #2: Substance Abuse Prevention and Treatment

Discussion

There is a need for both programs and professionals to work with youth around substance abuse and treatment issues.

Direct Services Identified Need #3: School Health Clinics

Discussion

There is a need for school health clinics to be a point of access for comprehensive health care. In addition, these clinics must be the coordinating agent between the school health clinics and the adolescents medical home.

Enabling Services Identified Need #4: Comprehensive Sexuality & Reproductive Health Education:

Discussion

There are two positions in the Department of Education that are funded through the Bureau of Health. These positions work on comprehensive health education curriculums. The Family Planning Association has family life educators who provide comprehensive health education.

Enabling Services Identified Need #5: Transportation:

Discussion

In addition to the issues of logistics and funding, an additional problem unique to this population is lack of transportation to off-campus after school activities.

Population-based Services Identified Need #6: Enrichment Programs:

Discussion

Clients identified a need for enrichment programs for all children, including Children with Special Needs. There were requests for programs in music, art, sports and self-esteem.

Population-based Services Identified Need #7: Life Skills Education:

Discussion

Requests for additional presentations of this program to promote youth self support and independence.

Infrastructure Building Services Identified Need #8: Dental Access

Discussion

This population also faces a lack of providers willing to accept Medicaid payments, under served rural areas, and particular to this population a lack of dentists who specialize in pediatric dentistry

Infrastructure Building Services Identified Need #9: Safe Places Before and After School

Discussion

A need for alternative recreation and transportation to these activities.

Population #3: Children With Special Health Needs

Direct Services Identified Need #1: Mental Health/Behavioral Health Services

Discussion

As with the previous populations, clients identified a need for services both for treatment and prevention. The big issue with this is that Medicaid will only pay for patients who have a diagnosis, preventing clients from obtaining preventive services.

Direct Services Identified Need #2: Continued support of Specialty Clinics

Discussion

The CSHCN Program needs to increase funding to specialty clinics (e.g.. Spina Bifida, Cleft Palate, Developmental, Cancer , Metabolism) in order to expand these clinics into the rural northern, area of the state.

Direct Services Identified Need #3: Occupational Physical/Speech Therapy

Discussion

The need for additional therapist, both in the preschools and grade schools was identified

Direct Services Identified Need #4: Hearing Screening

Discussion

Routine newborn hearing screening in Maine has been adopted on an individual hospital basis. Interest of birth hospitals/providers in providing this important screening prior to discharge is increasing. The program manager for the Genetics Program has participated in discussions with audiologists regarding implementation of a statewide initiative, and a legislative bill has been introduced (1999 Legislative session) that, if passed, will mandate universal infant hearing screening. This bill will be discussed during the next legislative session

Direct Services Identified Need #5: Comprehensive Medical and Developmental Services

Discussion

Clients identified a need for anticipatory guidance and prevention as well as treatment.

Direct Services Identified Need #6: Northern Maine Access Issues

Discussion

Those clients in the northern part of the state identified a need for increased availability and quality of services closer to home. Currently these clients must commute to either Bangor or Portland for services.

Population-based Services Identified Need #7: Enrichment Programs:

Discussion

Funding for transportation to programs others than those directly related to medical issues. Funds for recreational and enrichment programs in art, music, physical activities, self-esteem.

Population-based Services Identified Need #8: Feeding Support

Discussion

Clients residing in the northern part of the state identified a need for community resources to provide feeding support for parents of premature infants who have been discharged from the nursery.

A listing and discussion of Existing Preventive and Primary Care Services may be found in Section 2.4:

3.3. Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Please refer to Section V Forms and Supporting Documents Budget Columns on Form # 2,3,4, and 5

3.3.2 Other Requirements

Maintenance of effort: The State of Maine meets and exceeds the maintenance of effort requirements of Sec. 505(a)(4)

Justification:

The Division of Community and Family Health expended $8,737,339 for maternal and child health services in FY99; including $5,510,318 of state funds and $3,227,021 of Title V funds. Expenditures by populations served include 55% ($4,806,200) expended on primary care and preventive services for children; 25% ($2,144,252) expended for children with special health care needs; and 7.5% ($659,952) expended for pregnant women. Delineating expenditures by the levels of the MCH Core Services Pyramid, 57% ($4,946,974) was expended on direct services; 10% ($897,724) was expended on enabling services; 10% ($845,545) was expended on population based services; and 23% ($2,047,097) was expended on infrastructure building services. In FY01 the Division proposes to spend $3,497,292 of Title V funds, with no carry forward from FY00. Of the Title V funds, 37.33% ($1,305,401) is allocated to primary and preventive services for children; 33.89% ($1,185,322) is allocated to children with special health care needs; and 4.96% ($173,438) is available for administrative expenses. Considering the total federal and state budgets, the Division proposes the following expenditures categorized by level of the MCH Core Services pyramid: 68% ($10,850,299) will be allocated for direct services; 4% ($694,337) for enabling services; 12% ($1,880,596) for population based services; and 16% ($2,569,840) for infrastructure building services.

3.4 Performance Measures

Please refer to Section V Supporting Documents: Forms # 11,12, and 13.

3.4.1 National "Core" 5-Year Performance Measures

Please refer to Section V Supporting Documents Figure 4. See Form 11 for 5 year targets.

3.4.2 State "Negotiated" 5-Year Performance Measures

Please refer to Section V Supporting Documents Forms 11 and 16.

3.4.3 Outcome Measures

Please refer to Section V Supporting Documents Form 12

IV. REQUIREMENTS FOR THE ANNUAL PLAN
4.1 Program Activities Related to Performance Measures

4.1.1 Children with Special Health Care Needs Program

Federal Performance Measure 01

The % of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) program.

Federal Performance Measure 02

The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Federal Performance Measure 03

The % of Children with Special Health Care Needs (CSHCN) in the state who have a "medical home".

Federal Performance Measure 11

% of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Federal Performance Measure 14

The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

State Specific Performance Measure 06

The knowledge of percent of Children with Special Health Care Needs.

Population: Children with Special Health Care Needs

DIRECT SERVICES

During FY01 the CSHCN Program will partially fund and support the following community-based interdisciplinary clinics: Developmental Evaluation Clinics in 5 locations; Myleodysplasia Clinic in 2 locations, Pediatric Oncology in 2 locations, Cystic Fibrosis Clinic in 3 locations, and the Children's Cerebral Palsy Clinics in 3 locations. However, this year will see a change in reporting practices. All grantees will be required to report on the Federal Performance Measures 1, 2, 3 and 11. We will begin assessing quality assurances by implementing in the reporting process those clinics that use clinical practice guidelines: Cystic Fibrosis, Myleodysplasia and Oncology clinics.

Southern Maine PKU and Metabolism Clinic

Currently the Southern Maine PKU and Metabolism Clinic meets four times per year. The Program intends to hire a Nurse Coordinator to fill a vacancy. With this position filled the Program will increase the number of available clinics to 12/year. Enhancing these clinical-based services will fill a niche in Southern Maine and compliment those services already available in Northern Maine at Eastern Maine Medical Center. During FY01 the CSHCN Program will host a meeting of the two clinic personnel to discuss the comprehensiveness of the services provided. The PKU camping weekend will again be held in Spring 2001.

Cleft Palate Clinic

During FY01 the CSHCN Program will provide 24 clinics in two sites; Bangor and Portland. The CSHCN Nurse Coordinator and the Public Health Nursing Resource Group will work collaboratively to ensure that services are family-focused, community-based and culturally-competent.

ENABLING SERVICES:

Care Coordination Services

The CSHCN will continue to provide care coordination services to all children with special health care needs who access the Program directly or through community-based clinic programs.

CSHCN Payment of Services

During FY01 the CSHCN Program will increase the income eligibility guidelines from 225% of the Federal Poverty Level (FPL) to 300%. This increase in the income guidelines will allow the Program to focus its attention of those children not covered previously by any program. This increase will also compliment the SCHIP Program whose income guideline is set at 200% of the FPL.

Enhanced Referrals

During FY01 the CSHCN Program will be available to the SSI recipients who are medically eligible for the program. The Program intends to collaborate with the Disabilities Determination Unit (DDU) to enhance referral services not only to our program but also to the Department of Mental Health Mental Retardation and Substance Abuse and the Department of Labor - Vocational Rehabilitation Unit. The new management information system will allow us to accurately count the number of referrals we receive from DDU and to track referrals we have made to other agencies.

Uninsured and under insured

The CSHCN Program will continue to cover those special needs children who are uninsured or underinsured. We will continue to promote and send parents an application for the SCHIP Cub Care Program.

State Statute

It has been recommended by families, members of the Family Advisory Council, members of the CSHCN Strategic Planning Group and Program staff to change the existing name of the program and to increase the age of the children we serve. The CSHCN Program will through the legislative process change the name of the program from the Crippled Children's Program to the Children with Special Health Needs Program; and increase the age of the children served from 0 up to the age of 18 to 0 up to the age of 21.

POPULATION BASED SERVICES:

Family Advisory Council

The CSHCN Program will continue to support the FAC both financially and with staff personnel. During FY01 the CSHCN Program, with the assistance of the FAC, will hold its first annual Family Meeting. The Program will work with the FAC in re-designing the CSHCN brochure and application.

Workshops

The CSHCN Program will continue to assist families to attend conferences and workshops.

INFRASTRUCTURE BUILDING SERVICES:

Newborn Hearing Screening Initiative

The CSHN Program and the Genetics Program will work collaboratively to implement this initiative at all birthing hospitals. The CSHCN will contribute a half-time comprehensive health planner to the initiative.

Medical Home

The CSHCN Program will continue to ensure that children who receive services are connected to a medical home. During FY01 the CSHCN Program will be working with the Hood Center for Children and Families at the Children's Hospital at Dartmouth, NH and their MCHB Medical Home Project. During FY00 two pediatric offices were selected as pilot sites to implement this project in Maine. The physicians and staff of these two offices met with the Hood Center personnel and planned a meeting for August 2000. Over the next year the Hood Center will work collaboratively with the two physician offices to design and improve community-based pediatric medical home services to children with special health care needs and their families.

4.1.2 Genetic Services Program

Federal Performance Measure 04

The % of newborns in the state with at least one screening each of PKU, hypothyroidism, galatosemia, hemoglobinopathics (i.e. sickle-cell disease) (combined).

Federal Performance Measure 10

Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Federal Performance Measure 18

The % of infants born to pregnant women receiving prenatal care beginning in the first trimester.

State Performance Measure 07

Timely provision of genetics services.

Population: Pregnant women, mothers, infants, children, children with special health care needs

Birth Defects

There is continued interest in the causes and effects of birth defects in Maine and specifically support for the development of a Birth Defects Surveillance System/Program. The Genetics Program has a cooperative agreement with the Centers for Disease Control and Prevention to develop and implement a state-based surveillance system. The award is $100,000 for each of three years (1999 to 2002). The Birth Defects Program will use the data from the registry to plan programs for prevention and direct services.

Existing data sources, including vital records, do not provide complete information regarding the occurrence of birth defects in Maine. More complete information is needed for comprehensive program planning and prevention efforts. Stakeholders meetings have highlighted the need for prevention activities including: education on folic acid and prevention of birth defects, early identification of those at risk for problems (i.e. birth defects, other health problems and developmental delays), care coordination/case management, other early intervention services, access to specialty services, team based services and the need for a Web-based Statewide Resource Directory.

The Genetics Program will continue to work with CDC and consultants to develop a statewide surveillance system. The Program manager will participate in regional meetings held by New England Regional Genetics Group, Inc. that are related to birth defects surveillance activities.

CSHN and PHN will provide families with information regarding available resources and services. A statewide resource directory will be developed and maintained in collaboration with Maine Parent Federation: Special Parents Information Network. The directory will be web based with hard copies available on request.

POPULATION-BASED SERVICES ¾ INFANTS

Newborn Screening

New technology, Tandem Mass Spectrometry, offers the potential to screen for 20 or more rare conditions that, if left untreated, result in morbidity and mortality. A series of meetings for the Newborn Screening Advisory Committee will be held to discuss additional conditions to screen for and to make recommendations. Outside consultants will be contacted to facilitate discussions. Meetings will be held September to December, 2000

The Genetics Program will continue to provide UPS courier pick up of newborn screening specimens and will maintain close contact with birth hospitals, providers and specialists to assure prompt identification and treatment of affected infants. The MCH computer programmer will consult on improved data management. Each identified case will have documentation of confirmation of diagnosis, referrals, treatment and outcomes. Staff will collaborate with Public Health Nursing and Community Nursing agencies, school nurses, CSHN and providers to locate affected children, and provide information and rapid access to treatment to reduce morbidity and mortality associated with untreated genetic defects.

Newborn Hearing Screening

Currently there are only 9 birth hospitals in Maine that offer hearing screening for all newborns and 1 other hospital that screens “at risk” newborns, providing access to screening for 39.9 % of Maine newborns. There are 12 other hospitals that are planning to begin screening in the near future. The Legislation that was passed does not mandate newborn hearing screening, but requires hospitals and other providers who do testing on infants and young children to report the results to the state. Technical assistance and capacity building for newborn screening are needed in several areas of the state.

Funding will be sought to support the Newborn Hearing Screening Program. The Genetics Program and CSHN will provide technical assistance to hospitals and collaborate with the Maine Academy of Audiologists and the University of Maine regarding systems development and tracking.

INFRASTRUCTURE BUILDING SERVICES ¾ WOMEN & INFANTS

Comprehensive Genetics Services

The Genetics Program will continue to provide grant funding to agencies providing comprehensive genetic/care services. Services will be provided through grantee agencies, even if families are unable to pay.

Agencies will continue to document both date of service referrals and date genetic clinic services were received. This time lapse (timeliness) will continue to be used to evaluate access to services.

FY00 agency reports show a decrease in the numbers of clients served, partly due to changes in agency staffing levels. Stakeholder meetings identified concerns about uneven distribution of specialty services and the excessive time and distance necessary for rural inhabitants to access services and appointments. Primary care physicians are gatekeepers for access to specialty services, and as such, must be knowledgeable in the area of genetics, able to integrate principles of genetics into their practice and aware of genetic services available in Maine. Increasing awareness of genetics issues through education for providers and the public may improve referral rates. Access may also be improved through outreach clinics. Genetics agencies receiving grant funding will be required to provide education for providers and the public and also to provide services through outreach clinics. Genetic agency grants will include a plan for education of providers and the public

The program will develop a survey for providers to ascertain their knowledge of genetics. The program will collaborate with Licensing and Certification to distribute the survey with license renewals for physicians and nurses in advance practice. Similar surveys will be included with any grand rounds presentation or other educational program. Families of children with genetic disorders/birth defects will be interviewed or surveyed to determine if they received genetic information in an appropriate manner.

INFRASTRUCTURE BUILDING SERVICES ¾ CSHCN

Birth Defects

The Genetics Program will continue the development and implementation of a Birth Defects Program. Case definitions will be determined in consultation with a dysmorphologist and CDC staff. An Advisory Committee with representatives from hospitals, physicians, affected individuals/families and others will provide the program with input. Rules have been drafted and will be promulgated that outline program functioning. Contracts will be written for consultation in dysmorphology and also for medical record abstraction conducted either by outside consultants or staff who will be hired and trained. This program will serve to help identify CSHN and allow for PHN and CSHN programs to assist the family with referrals and resources. A Statewide Resource Directory will be developed by the "Maine Parent Federation: Special Needs Parents Information Network" to provide up to date resource information for individuals, families and providers.

4.1.3 Teen and Young Adult Health Program

Federal Performance Measure 06

The rate of births (per 1000) for teenagers aged 15 through 17 years

State Performance Measure 01

Access to comprehensive health care services to serve adolescents.

State Performance Measure 02

The % of unintended births in women less than 24 years of age.

Population: Adolescents and young adults

DIRECT HEALTH CARE SERVICES

Access to services is an important tool for reducing unintended births. The Teen and Young Adult Health (TYAH) Program will continue to focus on women younger than 24 years of age by contracting with the Maine Family Planning Association (FPA) to provide reproductive health services to reduce this age group's rate of unintended pregnancy to no more than 54.7%. It is expected that the FPA clinics will continue to provide services to approximately 33,000 clients per year through 32 family planning clinics. Services include screening for high-risk conditions, education regarding contraceptive choices and the provision of an effective contraception method. It is expected that at least 79% of family planning clinic clients will receive an effective method of contraception.

ENABLING SERVICES

The TYAH program will continue to support 14 statewide Adolescent Pregnancy/Parent (APP) projects. The Division of Community and Family Health (DCFH) will work cooperatively with the state Community Service Center (CSC) which provides half the funding to support the projects. These projects serve pregnant and parenting teens by assisting them to receive timely prenatal and routine medical care, continue their education, learn appropriate parenting skills, and obtain referrals and follow-up to other necessary services. All projects encourage pregnant and parenting teens to stay in school and to delay repeat pregnancies. Ten of the projects offer support groups, five in schools and five at their service sites. Group topics vary according to need and may including parenting, injury prevention, nutrition, child care, relationships, contraception, and preparation for childbirth. In FY00, these projects will be put out to bid and some new community agencies are likely to receive funding. However, we expect to again serve approximately 1800 pregnant and parenting teens, their children and partners. In addition, at least 84% of participants are expected to receive early prenatal care, and less than 5% of participants are expected to have low birth weight babies as a result of program activities.

POPULATION-BASED SERVICES

The TYAH currently funds two primary adolescent pregnancy prevention programs. The first program has a Pediatric Nurse Practitioner facilitating support groups for Norway middle school students who are at risk for early pregnancy. Referrals come from counselors and guidance staff. The groups create safe environments where teens feel comfortable discussing and receiving support about avoiding pregnancy. The second program provides group activities designed to increase communication between mothers and their 10-14 year old daughters around issues of puberty. During FY01, this project will coordinate a third annual regional conference for 5th – 8th grade girls focusing on personal strengths and assets. These programs plan to serve 315 adolescents in FY01, and expect to reduce pregnancy rates and other risk factors.

Additional pregnancy prevention services are provided through a contract with the Family Planning Association (FPA) of Maine. Family Life Educators are available to schools to provide technical assistance for developing curriculum, and conducting class discussions on pregnancy prevention and healthy behavior choices of everyday life. The program expects to have contact with 1460 educators, 3975 students and 2060 parents and community members in FY01. The FPA also manages mini-grants for community primary prevention of pregnancy programs. FY01 will be the second year of these grants, which target communities that have adolescent pregnancy rates above the state average. Five communities received grants last year.

Funding is also provided to the Peoples Regional Opportunity Program (PROP) in Portland to conduct training for school and community programs that wish to offer a peer leader program. Adolescents who become peer leaders are provided with training to increase their skills in listening and offering guidance to other students around a variety of issues including pregnancy prevention. PROP provides technical assistance to peer leader programs throughout the state and organizes an annual peer leader conference. The program expects to provide assistance to at least 5 new Peer Leader programs and to continue contact with existing programs.

The TYAH program provides staff support and oversight to the Abstinence Education project. In FY01, the project will continue to fund a media campaign targeted at young adolescents ages 12 to 17 and their families. We expect to reach 55% of the targeted adolescents. Based on feedback from the first two years, media spots will continue to focus on parent/child communication, aspirations, alcohol and sex, refusal skills, and the consequences of becoming a teen parent.

INFRASTRUCTURE BUILDING SERVICES

School Based Health Centers have been an excellent venue to increase access to quality services for adolescents. SBHCs provide confidential medical services including diagnosis and treatment of acute illnesses and management of chronic health problems. Behavioral health services are available at most centers. The TYAH program is focusing on developing and maintaining new SBHCs. It will continue to provide funding to seven SBHCs and fund one new SBHC during FY01. Additional monies from the tobacco settlement fund will fund other new SBHCs in conjunction with Community/School related disease prevention programs. Our current efforts in capacity building include developing data collection and analysis systems to better monitor the services provided and increase third party payor reimbursement to promote sustainability.

Title V also supports comprehensive, sequential, age appropriate, and skill based school health education. MCH funds will continue to support two School Health Education Consultants. These consultants, based within the Department of Education (DOE), provide leadership in the development of school health education policies. They

provide technical assistance to school districts through teacher education and direct consultation on curriculum development. The TYAH program funds a Resource Center at the University of Maine's Orono campus that provides a site for teachers to borrow health education resources.

In FY00 and FY01, The TYAH program will work collaboratively with the DOE to prepare for the 2001 Youth Risk Behavior Survey (YRBS). The TYAH staff will continue to participate on the Maine School Health Education Coalition, Kids Count, Suicide Prevention, Prevention Advocacy for Youth, School Health Advisory Council, Family Planning Clinical Advisory Committee, and the School-Based Mental Health Committee. In addition, the TYAH program facilitates statewide meetings for the Adolescent Pregnancy and Parenting Projects, and for all School-Based Health Centers. The TYAH program will continue to support the Maine Council for Adolescent Health, a multi-disciplinary group that advocates for adolescent health.

The TYAH program will provide training in FY01 to assist grantees with logic model development as part of program evaluation and capacity building activities. Other trainings such as grant writing and coalition building will be offered to grantees in conjunction with other DCFH programs. An adolescent pregnancy conference will be held in FY01 for service providers and community groups. In FY01, the DCFH will collaborate with the CDC, community providers and agencies providing services to teens to develop a system to monitor Maine adolescent pregnancy data i.e. family planning clinical data, vital statistics, and PRAMS.

4.1.4 Oral Health Program

Federal Performance Measure 07

The % of third grade children who have received protective sealants on at least one permanent molar.

State Performance Measure 04

The percentage of children with obvious need for dental care.

Population: Children

ENABLING SERVICES:

Good oral health is a fundamentally enabling condition in healthy productive lives. The Oral Health Program's (OHP) goal is to improve the oral health of all Maine citizens, but a considerable focus is on children. Like many other states, Maine has not been able to document, demonstrate or evaluate the effectiveness of its efforts in oral health because of a lack of reliable data. In late 1994, the OHP (then the Division of Dental Health) began a needs assessment process, using the Seven-Step Oral Health Needs Assessment Model developed by the Association of State and Territorial Dental Directors (ASTDD) in conjunction with the Maternal and Child Health Bureau. Although limited primary data, some secondary data, and descriptive information was collected, a report was not completed at that time because of staff constraints, reorganization in the Bureau of Health, and other issues.

The needs assessment process was resumed beginning with an advisory committee meeting in May 1998. At this meeting, data on many of the elements outlined in the ASTDD Model were presented in an interim report. Among the outcomes of the meeting was confirmation of the decision to go ahead with primary data collection through a statewide screening of schoolchildren in grades kindergarten and three. It was also confirmed that Maine's initial needs assessment focus would be on children, although other data, especially that which can be easily obtained, should be collected or updated as well. In the following months, the OHP developed contracts with (1) an oral epidemiologist for the sample and study design, as well as the questionnaire and data analysis plan to ensure validity and ability to generalize information correctly; and (2) a local dental provider to coordinate and conduct the screenings, which began in the spring of 1999 and continued into the fall and winter of 2000. Screenings took place in 50 schools across the state and included 2,459 students. The results of this assessment will also be used to describe the system of services available and the extent of unmet need, and should serve as the cornerstone for developing a comprehensive oral health program plan. Screening data analysis has been completed and final updates of secondary data are pending. The final report should be completed by the end of the summer of 2000

The promotion of oral health needs to begin early, and must be considered an integral part of a child's general health care. Children are an excellent focus for preventive strategies since early dental disease is preventable, and reversible. Treatment can prevent progression to advanced painful and destructive disease, a progression that is also quite costly. Through programs such as WIC, Well Child Clinics, home visits by Public Health Nurses, and other community-based programs, families of infants and young children being served by MCH

programs will continue to receive information on appropriate feeding and parenting practices for achieving good oral health, including fluoride supplementation.

In cooperation with DCFH's Public Health Nursing Program, and with support from Title V funds, OHP would like to continue to provide the educational opportunities that have been available through the Preventive Dental Program in DHS-funded Well Child Clinics. This program provides parental education, toothbrushes, and supplemental fluoride as needed to children who attend these clinics. However, with decreased attendance at these clinics, and fewer children receiving fluoride from the OHP, the OHP will be evaluating this program component during the coming year. With input from the Public Health Nurses who have been involved in administering the program, OHP will look at cost-effectiveness and cost benefit aspects, and explore alternatives in order to decide what the best way is to provide such services to these children.

Maine's EPSDT program, now called HealthWorks and administered by the Bureau of Health, has the responsibility to assist all Medicaid-eligible individuals under age 21 find dental services. The OHP was involved in adding anticipatory guidance for oral health into the EPSDT visit schedule, with oral screenings required at ages six months, one, two and three years; OHP staff continue to work with EPSDT staff to fully integrate oral health screenings and services into the periodicity schedule. A change in OHP staffing delayed efforts started two years ago to develop training opportunities for non-dental primary health providers to assist them in conducting these screenings, providing appropriate education, and making referrals. This project has been resumed and a training program, anticipated to be ready the fall of 1999, is still being developed in collaboration with other parties, including the Dental Hygiene Program at the University of New England and with growing interest from the Maine Dental Association. Training using the developing model was presented to WIC nutritionists during the winter 1999-2000, and will be adapted for presentation for Public Health Nurses during the fall of 2000. Because it may be difficult for physicians and other medical providers to locate dentists willing to see very young children, and because many dental professionals themselves are unfamiliar with managing this age group, a statewide effort is planned to educate general dentists and dental hygienists about the methods used in behavioral management techniques for children under three. Treatment modalities commonly used by pediatric dentists will be shared with general dentists. OHP staff will be central in the planning of these efforts, and will work to reinforce the role of non-dental primary health providers in promoting oral health throughout childhood, both within and outside of the EPSDT program. The OHP plans to work in collaboration with the Maine Dental Association, which has identified this area as a priority.

POPULATION-BASED SERVICES

The number of schools in primarily non-fluoridated communities participating in the OHP-sponsored School Oral Health Program (SOHP) - formerly the School Dental Health Education and Fluoride Program - will be maintained or increased, and oral health education information and assistance will continue to be provided to non-program schools. The SOHP is a voluntary, classroom-based oral health education program that includes a fluoride mouth rinse component in many communities. Beginning with the 1998-99 school year, MCH funds have been used in conjunction with existing funding to add a dental sealant component to School Oral Health Programs who apply to add this service to their activities; through this component they provide screening and sealants to second-graders. Funding is available for five years, so schools can continue to offer sealants and check retention for children who received sealants through the programs. The OHP plans to increase the number of schools funded each year for the sealant component, within funding constraints. Staff of the OHP will continue to offer specific training on a yearly basis for schools adding sealant components to their programs. In addition, four regional annual meetings are planned for early fall 2000 for the on-site program directors in schools participating in the SOHP. These meetings

serve as an annual inservice for the program directors, providing them with appropriate updates regarding SOHP administration as well as information related to program content. In August 1999, the OHP received a three year grant award from the federal Maternal and Child Health Bureau that supports expansion of school-based sealant programs. These funds are being used to support sealant programs in particularly rural and under served areas of the state (the Sacopee Valley area in southwestern Maine, and Aroostook and Washington Counties), leaving the state funds to support programs in other areas. In the 1999-2000 school year, 12 SOHPs offered sealant programs in 37 schools; more are expected to participate in the 2000-2001 school year (applications are pending as this report is being prepared).

The OHP continues to use Title V funds to partially support community-agency sponsored dental health education programs in two of Maine's most rural counties (Aroostook and Washington). Both programs provide coordination and support to SOHP and serve as oral health promotion resources in their areas, by providing community education, pre- and inservice training to social services personnel, teachers, etc., working with Head Start and day care providers, and other activities, such as developing grant applications for other funding and planning community events. These agencies will also serve as subcontractors for the MCHB sealant grant described above. The OHP will also continue to administer small grants totaling $64,000 to three agencies (two private non-profits and one municipal health department) to support 4 of the state's non-profit dental clinics, located in Portland, Bath, Bangor, and Chester. In addition, the OHP will be responsible for administering a new "Dental Services" program authorized by the State Legislature in the budget approved in June of 1999 and using tobacco settlement funds that will be available beginning July 1, 2000. This effort is described in the section on infrastructure building.

INFRASTRUCTURE BUILDING SERVICES

The Oral Health Program continues to provide statewide consultation and technical assistance to groups working to establish community-based oral health programs and services to improve the oral health status and access to care of low-income and Medicaid-eligible children and their families. For example, a mini-grant program intended to assist such groups in their planning or capacity-building efforts was implemented during FY98. It included two needs assessment projects, one focusing on the preschool age population; and two groups using the grants to support coordination of resources as they implement community clinics. Outcomes were briefly described the report for the year ending June 30, 1999.

The OHP's activities within the three federally supported projects referenced in that report – the Maine Dental Sealant Project and the Maine Oral Health Partnership Project (Oral Health Integrated Systems Development grant) from the federal MCH Bureau, and the "Maine School Oral Health Initiative" funded by the CDC – will assist in the development of infrastructure for oral health. The Sealant Project is briefly described above. The goal of the Maine Oral Health Partnership Project is to support the development of an oral health infrastructure in Maine by working to support, sustain and expand the work of the state Dental Access Coalition and to assist community groups in developing capacity for oral health education and clinical services. The Maine School Oral Health Initiative's intent is to facilitate Maine's ability to strengthen, improve and evaluate school oral health programming, and improve access to oral health education, promotion and treatment services for at-risk school-aged children. This last project will be closely coordinated with Maine's Coordinated School Health Program, a joint program between Maine's Department of Education and the Bureau of Health.

In addition, as noted above, the OHP will be responsible for administering a new "Dental Services" program authorized by the State Legislature in the budget approved in June of 1999 and using tobacco settlement funds available beginning July 1, 2000. Through this program, support (up to $250,000) will be available for public and private non-profit organizations for the development and expansion of oral health care programs; for case

management and community oral health education ($50,000); and for subsidies to programs providing clinical dental services to offset their sliding fee scales up to the level reimbursed by Medicaid (up to $650,000). Details of this program are still being worked out. Funds are expected to be contracted by the end of calendar year 2000.

Other activities planned for the Oral Health Program during FY 2000 include:

- Maintain and promote the School Oral Health Program (SOHP), and expand as feasible depending on availability of funds.
- Revise and/or develop oral health curricula for grades 2-3 and 4-6 (plans are to use a consultant).
- Develop and implement a National Children's Dental Health Month Campaign for February 2001 in cooperation with the Maine Dental Association, and/or other partners as identified.
- Continue lending and providing oral health promotion and education materials to schools, community groups, dental and other health professionals, and others.
- Revise and update the OHP educational resources list; implement and refine materials tracking system.
- Review, obtain, revise/update and/or develop as appropriate new materials, including those written at lower literacy levels, on selected topics.
- Continue to distribute a biannual newsletter specifically targeted to schools through the SOHP and other channels; resume publication of OHP program newsletter geared for broader audience (two issues planned).
- Establish and maintain collaborative efforts with other programs, agencies and organizations to integrate oral health into other health promotion efforts, through providing training, integrating program efforts, providing newsletter articles, etc.; working with programs such as but not limited to the Healthy Families Program and WIC; and involvement in tobacco control related activities.
- Continue to participate in community health promotion events, such as school and community health fairs and related events, as appropriate.
- Continue working collaboratively with the Bureau of Health's Drinking Water Program to monitor fluoridated community water systems for compliance with testing requirements as well as maintenance of optimum levels, and to facilitate appropriate education and training for water system personnel. This next year will see an increased effort to enhance communications with fluoridated water systems to support their compliance with testing and reporting standards as well as maintaining optimum fluoride levels.
- Continue to provide technical assistance and consultation to local and statewide groups working to improve access to oral health services, including but not limited to the Maine Dental Access Coalition.
- Update and distribute a revised edition of the OHP resource directory, “Dental Clinics and Services for Low-Income Persons in Maine”, a resource tool for health and social service agency staff, pending sufficient new information since the 1999 edition.
- Conduct a Strategic Planning process for the Oral Health program during the early fall 2000, including program staff, the program’s immediate supervisor, and several outside stakeholders.

4.1.5 Childhood Injury Prevention & Control Program

Federal Performance Measure 08

The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children.

Federal Outcome Measure 16

The rate per 100,000 thousand of suicide deaths among youth aged 15-19children aged 1-14

State Performance Measure 05

The motor vehicle death rate among children 15 to 21 years of age.

Unintentional Injury Program

ENABLING SERVICES

During FY01, MIPP staff will continue to:

- Provide technical assistance to its Safe Community Coalitions (SCC) on the proper installation of child passenger safety seats. MIPP will also provide information on how individuals may obtain free or loan safety seats within SCC service areas.
- Provide child safety seats and technical assistance to 60 child safety seat loan programs throughout the state. The program will distribute approximately 150 infant seats and 25 special needs restraints.
- Continue to provide child safety seats and technical assistance to 60 loan programs throughout the state. The program will distribute approximately 200 toddler seats, 250 booster seats, and 50 special needs restraints.
- Continue to work with the media in promoting and educating the public on child passenger safety issues.
- MIPP will continue to provide training and information to advocates on safe driving and the importance of buckling up.
- Oversee the development of at least one permanent fitting station in each of Maine's sixteen counties.

POPULATION BASED SERVICES

- Continue to provide ongoing child passenger safety educational materials to the Safe Community Coalition (SCC) sites for distribution upon request within their community.
- Provide annual child passenger safety training to loan program staff in Portland, Bangor, Caribou, and Augusta.
- Provide training and technical assistance to Bucklebear Project sites on child passenger safety issues.
- Provide child passenger safety technician training based on the National Highway Traffic Safety Administration, child passenger safety curriculum.
- Continue to provide up to date educational materials and resources on child passenger safety issues to professionals, advocates and the general public.

- Will collaborate with a variety of child safety advocates, including municipal agencies, to plan and implement a Home Safety Conference in September 2000. Topics will include fire, water, and firearm safety.
- Continue to provide its Safe Community Coalitions and other child safety advocates with injury prevention materials on a variety of topics, including fire, water, home safety, playground, bicycle, pedestrian, etc.
- Continue to provide safety and injury prevention seminars upon requests. Audiences include law enforcement, Corrections, Public Safety, employers, school health and safety sponsors, day care providers, police, fire, EMS, and other child safety advocates.
- Continue to regularly distribute Consumer Product Safety Commission recalls and information to approximately 80 agencies statewide, including Public Health Nursing, Rural Health Centers and Community Health Nursing on a quarterly basis.
- Continue to provide law enforcement, EMS and the Recreational Safety Division of Inland Fisheries and Wildlife and others the materials to conduct firearm safety demonstrations in their communities and statewide.
- Conduct 2nd one day firearm safety workshop in Fall 2000. Will distribute newly produced firearm safety video and accompanying discussion guide
- MIPP will work with Public Health Nurse Consultants to update "Your Child is a Rose" booklet. "Parents, Children & Discipline" booklet completed April 2000.
- MIPP, through a grant with the Maine Poison Center, will continue to distribute poison prevention educational materials, conduct media activities, education with preschool and elementary school age children and their parents reaching an estimated 10,000 consumers.
- Develop and maintain a list of Child Passenger Safety Technicians available to assist parents and caregivers on the proper use of child restraint systems in communities throughout Maine.

INFRASTRUCTURE BUILDING SERVICES

- MIPP will continue to collaborate and coordinate activities with the Maine Transportation Safety Coalition in promoting child passenger, bicycle, and pedestrian safety issues, including the Safe Communities concept.
- MIPP in collaboration with the Maine Transportation Safety Committee will continue to foster the development of safe communities throughout the state and will continue to identify and recognize local efforts through the Community Transportation Safety Award.
- The program will continue the development and maintenance of a Web site for dissemination of prevention information including prevention resource contacts, data, training opportunities and links to other Maine and national injury prevention resources.
- MIPP will continue to collaborate and coordinate on child passenger safety issues with the Maine Transportation Safety Coalition as well as other committee, and other state agencies involved in the safety of Maine's teen drivers.
- Data provided through all Maine Injury Prevention Program Fact Sheets will be kept current and distributed upon request.

- Award two to four new Safe Community Coalitions, while continuing to fund the two SCC, with a focus on unintentional injury prevention to infants, children and teens.
- MIPP has begun work with the Director of Emergency Medical Services to implement portions of a recent grant award made to Medical Care Development, including school and playground safety
- Continue to coordinate and collaborate with the Maine Transportation Safety Coalition in promoting bicycle, pedestrian, and school bus safety issues. This will be accomplished through the MTSC newsletter, road show and "Safety Is Always in Season" brochure.
- Work to identify additional firearm safety partners in the state to better address issues of firearms in the home.
- Through funding provided by the Cooperative Agreement with the CDC, the MIPP will lend resources and technical assistance to the Maine Independent Living Services to promote fire safety within Maine's hearing impaired population.
- Continue to work with fire service personnel throughout the state to promote residential fire safety, with particular emphasis on the need for Maine residents to install and properly maintain smoke alarm(s) on every level of their homes.
- Work with the media in promoting and educating the public on fire safety issues.
- Coordinate efforts among police, fire service, EMS and other health professionals in an effort to introduce *Risk Watch* into local schools. Risk Watch is a comprehensive school-based injury prevention curriculum developed by the National Fire Protection Association in conjunction with Lowe's Home Safety Council.

Intentional Injury Program

Population: Children & Adolescents

POPULATION-BASED SERVICES

- Through cooperative agreements with the University of Maine campuses in Orono and Portland, resource libraries containing conflict resolution educational and curricula materials will be made available to school and community groups statewide. A biannual newsletter, which provides information and networking opportunities, will continue to reach more than 2,500 individuals statewide.
- The Program will also continue to develop and maintain a formal resource list for individuals and agencies in Maine interested in Shaken Baby Syndrome education and prevention activities.

INFRASTRUCTURE BUILDING SERVICES

- An annual violence prevention conference for school personnel to increase their knowledge and ability to integrate violence prevention practices and policies into the educational setting will be conducted.
- Through a grant to the Attorney General's Office, Civil Rights Division, more than 100 school-based Civil Rights Teams will be provided training and technical assistance. Teachers, students, and other school staff will be trained in bias and hate crime prevention in each school by establishing or maintaining a school based civil rights team.

- Through cooperative agreements with the University of Maine at Orono and the University of Southern Maine, 20 schools will be assisted to establish school-based peer mediation and/or conflict resolution programs. Through the support of the University programs, a statewide association of peer mediators will be maintained. This organization allows young people, who are elected by their peers, to serve at quarterly meetings and attend annual conference designed by the youths for an audience of at least 100 peer mediators. The network of conflict resolution educators and peer mediation program coordinators, the C.O.R.E Network, will conduct regular meetings for the purpose of sharing program experience and expertise.
- The program will Web site youth violence prevention information. Resource contacts, data, training opportunities and links to other Maine and national youth violence prevention agencies.
- The MIPP will continue to monitor youth violence incidence and develop trend and other data reports. Data provided through the Maine Youth Violence Fact Sheet will be kept current.
- Training and technical assistance in the evaluation of youth violence prevention programs will be provided to state, university and school-based violence prevention providers based on the program logic model methodology.
- Continue to coordinate with hospitals to conduct Shaken Baby Syndrome prevention in-services to nursing staff and hospital sponsored parenting classes.
- Develop a system for monitoring Shaken Baby Syndrome incidence data including input from the Maine State Police, physicians and media reports.

Youth Suicide Prevention Activities:

Population: Children and Adolescents

ENABLING SERVICES

- Youth suicide prevention awareness education sessions will be provided to 1,000 individuals through statewide and regional conference workshops, and individuals trained by the Maine Youth Suicide Prevention Program to make these presentations in their communities.

POPULATION BASED SERVICES

- Materials, including a program brochure and a fact sheet for general audiences, posters, crisis hotline magnets and cards, and resource directories for teens will be disseminated. A Web Page will provide suicide prevention information and links to related resources.
- MIPP staff will continue to partner with law enforcement, EMS, and others to provide education and materials to parents and others about the need to restrict access to lethal means when a vulnerable youth is identified. One strategy is the development and distribution of a firearm safety video.
- MIPP will continue to partner with mental health agencies and others in the distribution of trigger locks to citizens to identify resources to purchase and distribute trigger locks to municipal agencies to support citizen outreach.

INFRASTRUCTURE BUILDING SERVICES

- One-day in-depth "gatekeeper" suicide prevention training will be continued for approximately 1,000 school and community individuals who are in close contact with youth. Train-the-trainer sessions will enable individuals to conduct 2-hour suicide prevention awareness workshops statewide. Suicide prevention will be incorporated into Comprehensive School Health Education in at least ten school districts. Suicide prevention training for police officers, college health and other college support staff, clergy, medical professionals, and substance abuse prevention and treatment staff, will be developed and delivered for individuals in these systems. Training for additional groups of adults and youths in key relationships with at-risk youth will be explored.
- Guidelines for school and community based youth suicide prevention strategies have been developed and will be disseminated on request.
- Education of media representatives on how to prevent suicide contagion will be planned and conducted.
- The MIPP will continue to monitor state and national youth suicide attempt and completion incidence, and will develop trend and other data reports for implementation committee members, DCFH staff, the Child Policy Committee and Children's Cabinet. Data provided through the Maine Youth Suicide Fact Sheet will be kept current. Data will also be provided on request through annual status report.
- Training in the evaluation of youth suicide prevention programs will be provided to state, university and school-based suicide prevention providers based on the program logic model methodology. Assistance in the development of logic models for specific prevention strategies will be provided.
- The MIPP will continue to coordinate the activities of the Youth Suicide Prevention Data and Evaluation Team including the review of data and program evaluation.

4.1.6

Women & Children's Preventive Health Services;
Public Health Nursing; Children with Special Health Care Needs; Teen & Young Adult Health;
Women, Infants & Children; Healthy Start/Families Programs

Federal Performance Measure 12
The % of children without health insurance.

Federal Performance Measure 13
The % of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Population: Women, Infants, Children and Adolescents

Access to health care continues to be an issue for many children, adolescents and adults in Maine. Well child clinics are operated through Public Health Nursing and some Community Health Nursing agencies. Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents has and will continue to provide the guidance for the standards of care in these clinics. Bright Futures recommendations were used in the development of the EPSDT schedules and recommendations. Bright Futures is also the standard utilized by the Bureau of Medical Services (Medicaid). All Managed Care Organizations (MCO's) operating in the State have adopted Bright Futures as a standard. The Maine chapters of the American Academy of Pediatrics and the Association of Family Practitioners have likewise adopted Bright Futures as their standard for well child care.

Maine's Child Health Insurance Program (CHIP) is a mix of Medicaid expansion and a state operated insurance program (CubCare) for children aged birth through 18 years.

As of June 1999 the CubCare enrollment of children is 6414. The exact number of uninsured is difficult to determine. Previous information was based on the one time Mathematica survey. The Mathematica survey was replicated in FY00. At present only preliminary data is available but it does indicates the CHIP is having a positive effect on increasing the number of low-income households whose children have creditable insurance coverage. On October 01,1999 CHIP eligibility increased to 200% FPL. Beginning September 01, 2000 parents whose income is less than or equal to 150% FPL, and whose children are insured through Medicaid, will be eligible for Medicaid insurance. The challenge facing Family Health Programs, Bureau of Medical Services, Bureau of Family Independence, and child and family advocates is not only to identify and inform eligible families, but then to link them to services so they actually enroll and utilize the health services available through the Bureau of Medical Services Medicaid Program.

4.1.7 Women and Children's Preventive Health Services Program

Federal Performance Measure 17

The % of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Population: Women and Infants

There are 38 acute hospitals within Maine, with most providing delivery services. The hospitals' capacities range from small community hospitals with level I nurseries, to two medical centers with level III nurseries (Maine Medical Center, Portland and Eastern Maine Medical Center, Bangor). Most of the providers are concentrated in the south and central regions of the state near the only two tertiary care centers. The rest are located in rural areas making access to perinatal services difficult due to geographical distances. Infrastructure has been developed to address this problem. Our infant mortality rate has been declining since the late 1980's. This infrastructure includes a sophisticated maternal and neonatal transport system; outreach provider education programs; home visiting programs; and community-based health promotion coalitions. All of these work synergistically to reduce infant mortality, reduce perinatal risk factors, reduce risks of labor and childbirth and to reduce poor childhood outcomes. Maine will continue to support the Perinatal Outreach Program and perinatal transport.

Maine, like the rest of the nation, is experiencing an increase in low birth weight and pre-term deliveries. The reasons for these trends are unclear, although perhaps due to increasing multi-gestational pregnancies. These issues will be a particular focus of the Maternal and Infant Mortality Review (MIMR) process being developed. The MIMR will analyze data and identify areas for further interventions to reduce pre-term deliveries and low birth weights. The anticipated hiring of two MCH epidemiologists (through SSDI and CSTE) will be of great benefit to the analysis of this and other data for use in systems and program planning.

4.1.8 Public Health Nursing; Women and Children's Preventive Health Services; Women, Infants & Children; and Healthy Families Programs

Federal Performance Measure 05

The % of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

Federal Performance Measure 09

The % of mothers who breastfeed at hospital discharge.

State Performance Measure 03

Percent of women breastfeeding infants at six months of age.

Federal Performance Measure 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Federal Outcome Measures

1. ***The infant mortality rate (deaths per 1,000 births from birth-364 days)***
2. ***The ratio of black infant mortality rate to the white infant mortality rate.***
3. ***The neonatal mortality rate per 1,000 live births.***
4. ***The postneonatal mortality rate per 1,000 births.***
5. ***The perinatal mortality rate per 1,000 live births.***

Federal Performance Measure 18

The % of very low birth weight live births.

Population: Women, Infants, and Children

Once a pregnancy has occurred, the timely initiation of prenatal care is critical. Outcome data demonstrates that the initiation of prenatal care during the first trimester is one of the key factors influencing birth outcome, i.e. carrying to or closer to term, and the decreased incidence of very low birth weight (VLBW) infants.
Maine continues with targets (with annual incremental adjustments) for the national performance measures #15,17, &18: Percent of very low birth weight live births, 1.0%; Percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, 90%; and Percent of infants born to pregnant women receiving prenatal care in the first trimester, 90%.

Activities supporting the achievement of the above mentioned goals include: assurance of access to prenatal services through private and public providers; Public and Community Health Nursing referrals for prenatal home visits for assessment, monitoring, and education of the pregnant woman and her family; referral of pregnant adolescents to adolescent pregnancy programs; referral as appropriate to Healthy Families, Parents As Teachers or Parents Are Teachers Too for pre and post-natal education and support; enrollment in WIC or referral to a registered dietitian; assistance in obtaining Medicaid/free care when needed; and assurance of access to comprehensive genetic services.

DIRECT HEALTH CARE SERVICES

Activities to maintain and improve the health status of Maine children are multiple and involve several programs receiving Title V funds. The Family Health Program is nearing completion of an evaluation of the PHN and CHN Well Child Clinics (WCC). The evaluation report, expected in the Fall of 2000, will include recommendations for meeting the educational and health care needs of the WCC population. Until this report's recommendations have been reviewed, the MCH block grant will continue to fund the well child clinics) operated through Public Health Nursing and the Community Health Nursing grantees. These clinics will continue to contribute, along with private and MCO primary care providers, to the efforts to attain the Healthy People 2000 goal, for performance measure #5, Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

Through the well child clinics and school programs, Maine's school children will continue to receive spinal screening. The Public Health Nursing program continues to maintain responsibility for the coordination and implementation of the annual spinal screening training for public health nurses, school nurses, and physical education teachers. Once again this will occur through a training session, broadcast via the interactive television (ITV) system in order to reach the targeted statewide audience.

ENABLING SERVICES

During FY01, the Public Health and Community Health Nurses will continue to conduct home visits for pregnant women, mothers and children to support a healthy pregnancy and/or support their transition to parenting. Visits will include medical and psychosocial assessment, monitoring of physiologic status, and education. Priority will be given to women and families identified as high risk for medical and/or social conditions, working to ensure understanding and compliance with treatments and medical regimens. While the initial referral may be related to an existing or potential medical concern, the home visit is a vehicle for education, particularly the area of prevention and cessation of high-risk behaviors, empowering these families to make healthful choices.

In addition to these home visits, first-time families will be eligible for education and support through the expanded home visitation programs. $4.8 million of Maine's tobacco settlement dollars have been appropriated to

expand family support and education services through home visitation programs. During FY01, the Family Health Programs will distribute those funds via RFP to community agencies for the provision of direct services. In addition, the FH program will provide technical assistance and support to agencies implementing these programs.

The Public Health Nurses and Community Health Nurses (the latter contracted through WCPHS), provide a wide range of educational activities. They serve as primary educators and also reinforce educational information through their varied and numerous activities. They are ideally situated to provide information and support in multiple and varied settings including office, home, clinic, and WIC facilities. Many of the MCH programs are ideally situated to be effective partners in the CHIP outreach activities. This is particularly true for Public Health and Community Health Nurses, and the Healthy Families home visitors. They have the skills and venues to provide education regarding the Title XIX and XXI programs, eligibility, and assist with the application process.

POPULATION-BASED SERVICES

At the beginning of CY98, the transfer of EPSDT Outreach activities to the Bureau of Health coincided with the need to update the EPSDT materials. The increasing diversity of Maine's immigrant population resulted in the development of more culturally sensitive and appropriate materials. These new materials are now available for use by healthcare providers and MCH program staff. Efforts to ensure culturally sensitive and appropriate responses and practices are ongoing. Many of the Family Health program managers remain active on the EPSDT Advisory Committee and will continue to do so in FY01.

INFRASTRUCTURE BUILDING SERVICES

The DCFH will initiate a statewide MCH Advisory Committee as an outgrowth of the currently in progress Maternal Child Health Strategic Planning Process. The MCH Advisory Committee will evaluate and give recommendations regarding program initiatives and goals. Committee membership will be representative of the wide ranging MCH community, including clients, advocates, and community agency representatives.

The DCFH is continuing development of a Morbidity and Mortality Review Committee (MMRC) composed of representatives of existing morbidity and mortality reviews, as well as key community stakeholders, and Bureau of Health (BOH) representatives. The committee's goal is to review all child and maternal deaths within the state as well as explore issues of significant morbidity within the MCH population. These explorations will also assist the MCH Program in determining programmatic goals. A key activity of the committee will be communication with communities with a focus on generating reports and communication of the data and findings that will assist Maine communities in determining local priorities. Formation of a Maternal and Infant Mortality Review (MIMR) and a Child Fatality Review (CFR) are key components of the planned Maternal and Child Health Morbidity & Mortality Review Committee.

The MIMR convened for a planning meeting involving key community stakeholders in September 1999. This meeting was hosted by the Women and Children's Preventive Health Services Program (WCPHSP) and the Genetics/Birth *Defects Program. Meeting discussion include key focus areas for the MIMR, including decisions* regarding hospital care review. Progress implementing the MIMR has been delayed due to key positions becoming vacant and other key positions assuming responsibility for the day-to-day work of those vacant positions. Through other Bureau program budget cuts, staff will be reassigned to fill some of these vacancies. It is anticipated that implementation of the MIMR and the MCH Advisory Committee will once again be a main priority in FY01.

The Maine Child Fatality Review (CFR) has been collaboratively formed between the DCFH and the Medical Examiner's Office. The primary objective of this group is to review all child deaths within the state of Maine. Steps are being taken, with the assistance of the Attorney General's Office, to ensure the integration of this

system into the state MCH infrastructure. A representative from this review will also participate in the MMRC.

Initially, all cases will be reviewed within the membership which includes representatives of the Division of Community & Family Health (DCFH), the Office of Research, Development & Vital Statistics (ORDVS) and the Medical Examiner's Office. It is our hope that ultimately the review will respond to specific findings and concerns. Possible responses and interventions include specific hospital case reviews, grand rounds, and campaigns in response to trends and issues.

Maine's population is 98% Caucasian. English is the principal language followed distantly by French. Therefore, the need for translation services in the past has been limited. Over the course of the last decade our immigrant population from non-English speaking countries has been growing, resulting in an increased demand for translation services. In response to the increased demand for interpretive services, there are now more independent interpreter services available (i.e. the AT&T Language Line) which became available to DHS staff in early CY98) to improve access to translation services. Public Health Nursing will continue to use the AT&T language line and its contract with Catholic Charities of Maine for the provision of interpretive services for refugees in the Portland area. Several of the rural health centers provide care to the seasonal migrant workers therefore interpreter services are made available at some of the centers and arrangements can be made for their use by Public Health Nurses during home visits.

The Sudden Infant Death Program

Plans for FY01 include:

DIRECT HEALTH CARE SERVICES

Continued liaison role with the Office of the chief Medical Examiner and Public Health Nurses. Every family whose child under the age of 3 years dies unexpectedly will be offered a home visit by a Public Health Nurse. Public Health Nurse home visits will be offered through the first anniversary of the infant's death. The Public Health Nurse will be knowledgeable about Sudden Infant Death Syndrome (SIDS) and will be able to offer parents appropriate education and SIDS resources.

ENABLING SERVICES

Continued collaboration with the Maine SIDS Foundation (parent group). The goal will be to strengthen the peer contact offered by families to newly bereaved families.

INFRASTRUCTURE BUILDING SERVICES

The SIDS Program manager will remain knowledgeable about the research being done nationally and internationally regarding the possible causes of SIDS. The program manager will network with other states' programs to learn the best practices in services provided to families.

4.1.9 Nutrition Program; Women & Children's Preventive Health Services Program; WIC; PHN

Federal Performance Measure 09

The % of mothers who breastfeed at hospital discharge.

Federal Performance Measure 15

The % of very low birth weight live births.

State Performance Measure 03

Percent of women breastfeeding infants at six months of age.

State Performance Measure 08

"The percent of overweight children and adolescents."

Population: Pregnant women, Infants, Children & Children with Special Health Care Needs

A leading priority of the MCH Nutrition program is to improve the nutrition data linkages and data collecting systems on a statewide basis. Nutrition data has been collected on segments of Maine's population, however, there is not sufficient base line data available to adequately assess the nutritional status of the population. A nutrition surveillance system is essential for collecting and analyzing data to prioritize the needs to be addressed.

Additional data is needed regarding the nutritional status of Maine children. In particular, it would be advantageous to collect and analyze anthropometric measurements. Obesity and overweight are current public health issues and prevalent risk factors for chronic diseases. National data show that the percentage of young people who are overweight has more than doubled in the past thirty years. More than a third of high school students do not participate in vigorous physical activity on a regular basis. Diet and physical activity are the two primary behavioral factors believed to be associated with obesity and overweight.

In a 1988 University of Maine study, physical fitness levels of 30,000 Maine school children from kindergarten through twelfth grade were tested. The results showed that 82% of Maine boys and 75% of Maine girls had a higher percentage of fat as compared to national norms. This study also indicated that 72% of Maine boys and 64% of Maine girls had a lower level of cardiovascular fitness as compared to national norms. Data from the fitness study along with national trends of overweight and decreased physical activity indicate Maine youth may be overweight and inactive.

DIRECT HEALTH CARE SERVICES

The Nutrition Program will continue to provide medical nutrition therapy and special foods/formulas for individuals born with inborn errors of metabolism who have no other financial resources to pay for these services.

POPULATION BASED SERVICES

The MCH Nutrition Program will continue to support the annual MCH Breastfeeding conference and folic acid education.

INFRASTRUCURE BUILDING SERVICES

The MCH Nutrition Program will continue to collaborate with other State and Federal Nutrition programs such as WIC, School Nutrition Programs, Cooperative Extension, Child & Adult Care Food Program, Head Start and the Food Stamp Program to help improve the nutritional status of Maine's MCH population. Specific projects will include participation in the Maine Nutrition Council, the 5-A-Day Coalition, the Maine Nutrition Network, the Health Systems in Child Care Project, and the Coordinated School Health Program to enhance nutrition education/services for Maine People. The MCH Nutrition Program will continue to administer the USDA grant targeting nutrition education to Food Stamp Program participants in the MCH population. The work of this grant continues to be achieved via a cooperative agreement with the University of Southern Maine, Muskie School for Public Service, Maine Nutrition Network.

Surveillance and data collection are a key focus of the MCH Nutrition Program. The University of Maine and the MCH Nutrition Program will complete the analysis of the study to assess the nutritional/physical activity status of 9th grade students and determine any need for follow-up research and activities.

A State Nutrition and Physical Activity Plan was developed this past year. The goal of this plan is to improve the health and well-being of Maine citizens by outlining key issues, goals, objectives, strategies and policy recommendations to guide nutrition and physical activity programs. The plan will be completed by Summer 2000. The Nutrition Program will strive to achieve the recommendations of the Plan to support statewide infrastructure.

4.2 Other Program Activities

Please refer to Sections 2.4 “Progress on Annual Performance Measures” and 2.5 “Progress on Outcome Measures” for discussion of specific program activities, coordination with other agencies, and toll-free telephone numbers.

4.3 Public Input

Upon establishment of the Maternal and Child Health Advisory Committee all members will receive a copy of this plan. It will be distributed upon request to Department managers, staff, and stake holders, along with copies of the strategic plan. In addition, we place the following annual notice in local newspapers:

“The Maine Department of Human Services, Bureau of Health, Division of Community & Family Health is in the process of developing its application to the Federal Government regarding use of the Maternal and Child Health Block Grant (MCHBG) for FY01 (October 01,2000–September 30, 2001). These funds support public health programs to reduce infant mortality and morbidity, prevent injuries, provide dental health education, plan services, and provide clinical services. Although Congress and the Maine legislature have already earmarked some of these funds for various uses, the Division of Community & Family Health solicits input from interested organizations, providers and others regarding the implementation of these programs. The MCHBG application will be available to review upon request and to provide comments for the FY01 document. Please direct any inquiries to Belinda Golden at 207-287-9917 or 1-800-698-3624, or TTY 207-287-8015. Any comments or suggestions must be made in writing to:

Division of Community & Family Health
11 State House Station
Augusta, ME 04330
or by FAX to 207-287-4631
Your comments are required in writing.”

Note: To date we have not received any public comment from our newspaper postings.

4.4 Technical Assistance

Please refer to form # 14. We will request technical assistance from the Maternal and Child Health Bureau and other appropriate entities (i.e. the Center for Disease Control & Prevention) for the following:

1) Staff training in core public health issues to increase our internal capacity. This is needed because our staff have varying experience and formal education in public health issues.

2) Consultation and guidance specific to the development and evaluation of the Children with Special Health Care Needs strategic plan.

V. Supporting Documents

V. SUPPORTING DOCUMENTS AND REQUIRED FORMS

V. SUPPORTING DOCUMENTS

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http://www.fedstats.gov/